Catholic University Law Review

Volume 37
Issue 4 *Summer 1988*

Article 5

1988

From Baby Doe to Grandpa Doe: The Impact of the Federal Age Discrimination Act on the "Hidden" Rationing of Medical Care

Jessica Dunsay Silver

FROM BABY DOE TO GRANDPA DOE: THE IMPACT OF THE FEDERAL AGE DISCRIMINATION ACT ON THE "HIDDEN" RATIONING OF MEDICAL CARE

*Jessica Dunsay Silver**

In 1982, the news media reported the now-familiar story of "Baby Doe"—a Bloomington, Indiana infant born with Down's Syndrome and a blocked esophagus, who was being denied life-saving medical treatment and nourishment. Following this incident, a national policy debate focused on the treatment of handicapped infants. Were parents, with the acquiescence of physicians and hospitals, withholding medical care from infants born with physical and mental handicaps because they did not wish to keep these infants alive? Or were parents simply acting on the basis of reasonable medical judgments about the desirability of treatment? The debate also sparked a legal controversy: could the civil rights laws be used to inquire into the medical decisionmaking process, perhaps overturning a decision to deny treatment to a handicapped infant?

In 1984, the federal government responded to the Baby Doe incident by adopting regulations, pursuant to section 504 of the Rehabilitation Act of 1973,[1] that required hospitals and state child protective services agencies to take certain actions for the protection of handicapped infants.[2] The regulations were challenged and ultimately struck down by the United States

* Mrs. Silver supervises appellate litigation in the Civil Rights Division of the United States Department of Justice. She wrote this article while a Visiting Fellow at the American Enterprise Institute in 1985-1986. The views expressed herein are solely those of the author. Mrs. Silver expresses her appreciation to Irv Gornstein and David Marblestone for their advice in preparing this article.

1. 29 U.S.C. § 794 (1982). Section 504 provides: "No otherwise qualified [handicapped] individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . . ." *Id.*

2. The regulations, then codified at 45 C.F.R. 84.55 (1985), required health care providers to notify the public that withholding medical care from infants violated the federal prohibition against discrimination on the basis of handicap and required state agencies to formulate procedures to prevent neglect of handicapped infants and to intervene if necessary to protect a handicapped infant's health.

Supreme Court in *Bowen v. American Hospital Association.*[3] What was perhaps the most significant part of the Court's decision in *Bowen,* however, was lost in the controversy over the invalidation of the government regulations: the Court upheld the applicability of section 504 to a hospital's refusal to provide medical treatment to handicapped infants.[4] By so doing, the Court exposed medical treatment decisions made by health care institutions to scrutiny under section 504 and similar civil rights statutes.

The applicability of the civil rights laws to a hospital's medical treatment decisions has considerable significance beyond the protection of handicapped infants. The growing concern over spiraling health care costs has led those advocating cost containment to suggest the rationing of medical care. Some proposals, recognizing the public's antipathy to the notion of rationing medical care, suggest a hidden form of rationing. Instead of direct government intervention, they favor private, and unacknowledged, rationing by health care providers, primarily hospitals. Indeed, hospitals are already rationing some advanced technology, notably heart transplants. The elderly are the primary target of heart transplantation rationing. If, as this Article contends, a hospital's medical treatment decisions are open to challenge by older individuals under the civil rights laws, such as the Age Discrimination Act of 1975 (ADA),[5] hidden rationing will be exposed to scrutiny and eventually may be prohibited.

In Part I, this Article reviews the circumstances that have led to proposals for hidden rationing and suggests the impact such a scheme could have on older persons. Part II examines in detail the ADA, a statute which has been

3. 476 U.S. 610 (1986). The Court first ruled that the only issue to be decided was the validity of regulations issued by the Department of Health and Human Services (HHS). *Id.* at 652-26. The Court then held that the regulations exceeded the Secretary's authority because the logical and factual bases for the regulations were insufficient to support "federal intervention into a historically state-administered decisional process." *Id.* at 636.

The Court noted that because § 504 of the Rehabilitation Act of 1973 applies only to programs or activities receiving federal financial assistance, it has no application to a parental decision to withhold medical treatment from an infant. According to the Court, if treatment is withheld under such private circumstances, the infant is not "otherwise qualified" for treatment within the meaning of § 504 and the parental inaction does not violate that provision. *Id.* at 630. The Court concluded that the objective of the regulations, controlling parental decisionmaking, was clearly beyond the scope of the Rehabilitation Act of 1973. *Id.*

In response to the argument that the regulations applied only to the activities of hospitals and child protective services agencies, the Court stated that the regulations had not been confined to preventing unlawful discrimination and that there was no factual basis for concluding that those institutions had been violating § 504. *Id.* at 633.

4. The Court ruled that "handicapped infants are entitled to 'meaningful access' to medical services provided by hospitals, and . . . a hospital rule or state policy denying or limiting such access [is] subject to challenge under § 504." *Id.* at 624 (citing Alexander v. Choate, 469 U.S. 287, 301 (1985)).

5. 42 U.S.C. §§ 6101-6107 (1982).

virtually forgotten since its enactment. Based upon that examination, Part III analyzes the likely impact of the ADA on the use of age as a rationing criterion. The analysis concentrates on heart transplantation, where advancing age is currently a criterion for excluding prospective patients.

Regardless of the outcome of a challenge to the use of age as a criterion for rationing, however, the impact of the ADA on hidden rationing will be significant. The mere possibility of a legal challenge will expose the medical decisionmaking process to public scrutiny—much as it did during the Baby Doe crisis. Once hidden rationing is exposed, it cannot remain a private matter. Public policymakers will be forced to confront the serious issues surrounding the rationing of medical care.

I. RATIONING MEDICAL CARE

A. The Growing Pressure to Contain Health Care Costs

Until recently, national health policy has focused on increasing access to medical care and improving its quality. The establishment of Medicare[6] for the elderly and disabled and Medicaid for the poor,[7] as well as the pressures on employers to provide health benefits, are evidence of the importance Americans place on access to health care. Many believe that we have a "right" to an adequate level of health care.[8] Consistent with this view, the development of advanced medical technology has been seen as a positive effort to lengthen and improve our lives.

We have paid a price, however, for the increased quality and availability of health care. Between 1965 and 1981, total annual health care expenditures in the United States increased approximately 700%.[9] The percentage of the gross national product attributable to health care has grown, in the same period, from 6% to 10.8%.[10]

The high cost of medical care, combined with the aging of our population and resultant rise in the prevalence of chronic disease and disability, has raised serious concerns about the continuing escalation of health care ex-

6. *Id.* § 1395 a-xx.

7. *Id.* § 1396 a-p.

8. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, 1 SECURING ACCESS TO HEALTH CARE: THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES 4, 25 (1983) [hereinafter SECURING ACCESS] ("Society has an obligation to ensure adequate care for all."); OFFICE OF RESEARCH AND DEMONSTRATIONS, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, 5 THE NATIONAL HEART TRANSPLANTATION STUDY: FINAL REPORT, 45-37 (1985) (under contract to R. Evans & J. Broida) [hereinafter NATIONAL HEART TRANSPLANTATION STUDY].

9. 1 SECURING ACCESS, *supra* note 8, at 184.

10. *Id.*

penditures. Despite efforts to contain health care spending, the confluence of these factors has led some to predict that by the year 2000 the nation will be spending almost $2 trillion on health care, a figure that will account for fourteen percent of the gross national product.[11]

It is estimated that eighty percent of health care resources are devoted to chronic disease.[12] Over forty-five percent of those individuals aged sixty-five to seventy-four have some chronic disease,[13] and this percentage doubles in those over age seventy-five.[14] Moreover, during this decade, the number of individuals in this country who are over age seventy-five is projected to increase four times as fast as the population under age sixty-five.[15]

Much of the increased cost of health care has been attributed to advances in medical technology. Each year hundreds—perhaps thousands—of new technologies are developed.[16] Undoubtedly, some of these new technologies save money by reducing patient care costs. Nevertheless, improved technologies are considered responsible for between twenty-five and seventy-five percent of the increases in hospital costs.[17]

For example, coronary artery bypass graft surgery costs approximately $10,000 to $20,000 per patient and accounts for expenditures of $2 billion a year.[18] The annual cost of kidney dialysis is approximately $30,000 per patient, and total costs exceed $1.5 billion.[19] The yearly price tag for neonatal intensive care is also in the billions of dollars.[20]

Organ transplants are among the recent high cost "medical miracles." Physicians save lives by transplanting human kidneys, livers, hearts, pancreases, and bone marrow. The cost is considerable, ranging from $25,000 for a kidney transplant[21] to approximately $75,000 for a heart transplant.[22] Be-

11. Blendon, *Health Policy Choices for the 1990s,* 2 ISSUES IN SCI. & TECH. 65, 67 (1986).

12. Evans, *Health Care Technology and the Inevitability of Resource Allocation and Rationing Decisions* (pt. 1), 249 J. A.M.A. 2047, 2049 (1983) [hereinafter Evans I].

13. *Id.*

14. *Id.*

15. Arnet, *Health Spending Trends in the 1980's: Adjusting to Financial Incentives,* 6 HEALTH CARE FINANCING REV. 1 (1985).

16. Evans I, *supra* note 12, at 2049.

17. *Id.* at 2049-50.

18. Randall, *Coronary Artery Bypass Surgery,* 12 HASTINGS CENT. REP. 13-14 (1982).

19. Evans, Blagg & Bryan, *Implications for Health Care Policy: A Social and Demographic Profile of Hemodialysis Patients in the United States,* 245 J. A.M.A. 487, 490 (1981).

20. Evans, *Health Care Technology and the Inevitability of Resource Allocation and Rationing Decisions* (pt. 2), 249 J. A.M.A. 2208, 2212 (1983) [hereinafter Evans II].

21. HHS, ORGAN TRANSPLANTATION Q AND A 2 (1985).

22. OFFICE OF RESEARCH AND DEMONSTRATIONS, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEP'T HEALTH AND HUMAN SERVICES, THE NATIONAL HEART TRANSPLANTATION STUDY: EXECUTIVE SUMMARY ES-61 to 62 (1985) (under contract to R. Evans & J. Broida) [hereinafter EXECUTIVE SUMMARY].

cause transplant patients must continue to take immunosuppressive drugs to prevent rejection of the transplanted organ, follow-up costs can be as much as $6,000 to $12,000 a year.[23]

Today, every discussion of health care policy priorities focuses on cost containment. This, of course, is in line with our national emphasis on reducing government expenditures and controlling inflation.[24] The government is looking for ways to reduce health care spending. Employers are also searching for alternate means to halt spiraling health costs. Indeed, a desire to hold down the costs of medical care may be overtaking our interest in increasing quality and access to care as our number one health policy concern.[25]

Discussions of cost containment inevitably turn to the proliferation of expensive medical technologies, especially those, such as organ transplants, which involve high per patient costs.[26] Many serious commentators have long asked whether it is economically feasible to make new treatments widely available to all, regardless of cost.[27]

B. Explicit Rationing of Medical Care

Rationing of medical care—the deliberate denial of treatment to some individuals who might benefit from it—may seem alien to our conventional ideas about access to health care. Nevertheless, we have rationed medical care in the past and are doing so today.[28]

---

23. *Id.* at ES-60, Table ES-19.

24. Blendon, *supra* note 11, at 67.

25. Access problems still exist. Approximately 11% of the population is not covered by any form of public or private health insurance. 133 CONG. REC. E4821 (daily ed. Dec. 15, 1987) (statement of Rep. Sabo). The need for a system to finance long term care for the chronically ill becomes critical as the population ages. Various proposals for providing long term care for the elderly are under active consideration. Nevertheless, these issues do not have the priority they might have had in the past. Indeed, there is a "de facto moratorium" on proposals for national health insurance. Blendon, *supra* note 11, at 67-68.

26. Some attribute the problem of rising health care costs to an increased demand for low-cost services, such as laboratory tests, rather than expensive technologies. *See, e.g.*, Moloney & Rogers, *Medical Technology—A Different View of the Contentious Debate Over Costs*, 301 NEW ENG. J. MED. 1413, 1413-14 (1979).

27. *See, e.g.*, Baily, *"Rationing" and American Health Policy*, 9 J. HEALTH POL., POL'Y & L. 489, 499 n.2 (1984); Blumstein, *Constitutional Perspectives on Governmental Decisions Affecting Human Life and Health*, 40 LAW & CONTEMP. PROBS. 231, 250, 254 (1976); *see generally*, Evans I, *supra* note 12; Evans II, *supra* note 20; Mechanic, *Ethics, Justice, and Medical Care Systems*, 437 THE ANNALS 74 (1978); Schwartz, *We Need to Ration Medicine*, NEWSWEEK, Feb. 8, 1982, at 13.

28. In a sense, medical care has always been rationed. The cost of care makes it unavailable to many. Moreover, there are always limitations which result from a shortage of personnel or facilities. This rationing has been largely unplanned and implicit.

1. The Kidney Dialysis Experience

Kidney dialysis is perhaps the best known example of explicit medical rationing in this country. In 1960, the development of an effective means of artificial hemodialysis made it possible to treat patients with end stage renal disease.[29] The high cost of the procedure (approximately $12,000 to $15,000 a year), however, put it out of the reach of many patients.[30] Furthermore, in the 1960's and early 1970's, expenses related to the purchase of dialysis equipment and the employment of hospital personnel necessary to operate a dialysis program resulted in a shortage of treatment facilities.[31] Hospitals were able to provide dialysis to only a limited number of patients. As a result, various means of rationing were employed.[32] Hospitals applied selection criteria that included age, mental acuity, family involvement, criminal record, economic status, employment record, availability of transportation, willingness to cooperate in the treatment regimen, likelihood of vocational rehabilitation, psychiatric status, marital status, educational background, occupation, and future potential.[33]

For example, the Seattle Artificial Kidney Center created an anonymous screening committee to choose patients. The committee was composed of a physician, a lawyer, a housewife, a businessman, a labor leader, a state government official, and a minister.[34] One lay member reported his experience:

> The choices were hard . . . . I remember voting against a young woman who was a known prostitute. I found I couldn't vote for her, rather than another candidate, a young wife and mother. I also voted against a young man who [until he learned he had renal failure] had been a ne'er do-well, a real playboy. He promised he would reform his character, go back to school, and so on, if only he were selected for treatment. But I felt I'd lived long enough to know that a person like that won't really do what he was promising at the time.[35]

29. The kidneys normally remove metabolic waste products from the blood stream. When an individual has end stage renal disease, the kidneys cease to perform that function. Hemodialysis is the artificial means of cleaning the blood. Without this treatment, a patient with end stage renal disease will die. Rettig, *The Policy Debate on Patient Care Financing for Victims of End-Stage Renal Disease,* 40 LAW & CONTEMP. PROBS. 201-02 (1976).

30. Note, *Scarce Medical Resources,* 69 COLUM. L. REV. 620, 637 (1969)

31. Rettig, *supra* note 29, at 201-03.

32. There have been other shortages of drugs or medical treatments which resulted in rationing. For example, an inability to synthesize penicillin forced rationing of the drug during World War II. *See* Mehlman, *Rationing Expensive Lifesaving Medical Treatments,* 1985 WIS. L. REV. 239, 241.

33. Evans II, *supra* note 20, at 2209.

34. Note, *supra* note 30, at 661.

35. R. FOX & J. SWAZEY, THE COURAGE TO FAIL 246 (1974).

One pair of authors noted the "disturbing picture . . . of the Seattle committee measuring persons in accordance with its own middle-class suburban value system" and remarked ironically that "[t]he Pacific Northwest is no place for a Henry David Thoreau with bad kidneys."[36] The Seattle committee came to be known as the "God squad."[37]

By contrast, the Los Angeles County-USC Medical Center used a lottery to select dialysis patients. Initial screening on the basis of medical and other criteria placed a prospective patient into either an optimal or an alternate group. Candidates were chosen at random from the optimal group. When that group was exhausted, patients were selected from the group of alternates.[38] Other hospitals employed a queue ("first-come, first-served") system.[39]

The press focused national attention on the desperate plight of those needing dialysis.[40] A government sponsored committee recommended federal financing of hemodialysis.[41] By 1969, lobbying had begun in earnest.[42]

When Congress turned its attention to this problem in 1972, it rejected rationing outright. Confronted by a medical technology that could save lives, but was available to only a small percentage of those needing it, Congress chose to solve the shortage by simply expanding Medicare coverage to pay for kidney dialysis for virtually everyone.[43] Senator Vance Hartke articulated the fundamental question that faced Congress: "How do we explain that the difference between life and death is a matter of dollars?"[44]

The ease with which Congress assured universal access to kidney dialysis was undoubtedly influenced by the nation's secure economic situation.[45] Nevertheless, unrestricted access was provided at a high price to the government. Although initial costs were estimated at more than $30,000 a year per

36. Sanders & Dukeminier, *Medical Advance and Legal Lag: Hemodialysis and Kidney Transplantation,* 15 UCLA L. REV. 357, 378 (1968).

37. *See Nightline: Medical Miracles: Can We Afford the Bill?,* 4 (ABC television broadcast, Aug. 29, 1985).

38. Sanders & Dukeminier, *supra* note 36, at 372 n.45.

39. A queue system was used at Georgetown University Hospital, Montefiore Hospital, Yale-New Haven Hospital, and the Veterans Administration hospitals in Portland, Oregon and Bronx, New York. *Note, supra* note 30, at 659-60.

40. *See, e.g.,* Alexander, *They Decide Who Lives, Who Dies,* 53 LIFE, Nov. 9, 1962, at 102-04 (Seattle Artificial Kidney Center); Rettig, *supra* note 29, at 219-20.

41. Rettig, *supra* note 29, at 218.

42. *Id.* at 227.

43. Pub. L. No. 92-292, § 226A, 92 Stat. 307, 307 (codified as amended at 42 U.S.C. § 426-1 (1982)).

44. 118 CONG. REC. 33,003 (1972).

45. *Id.* at 33,007 (remarks of Sens. Jackson & Chiles). Senate debate reflected the irony of an affluent nation allowing people to die because they could not afford the treatment.

patient,[46] they were overtaken by medical realities. The dialysis program has grown from covering 10,000 patients in 1972, to covering 78,000 patients, at an annual cost of over $1.5 billion.[47]

2. Antipathy Toward Rationing

While the market system has traditionally been the means by which access to goods and services is provided, Americans have been largely unwilling to accept financial ability as the primary means of distributing medical care. Accordingly, Congress established Medicare and Medicaid to effectuate a national commitment to provide medical care to all, regardless of ability to pay. While this country has not achieved universal access to health care, it seems unlikely that we will resort to the market to govern access to new technologies. The government's decision to provide Medicare reimbursement for heart transplants[48] demonstrates its opposition to the rationing system that would result if federal reimbursement for new and expensive technologies was denied.

It is certainly possible to design a rationing system, based on social worth criteria, that is less arbitrary than the Seattle scheme.[49] Selection criteria could include life expectancy, family role, and potential future or past contributions to society.[50] But we reject the notion of evaluating the relative worth of individual lives because it is inconsistent with the basic principles of human equality.[51] Even if we were willing to make the evaluation, consensus would be achieved only at the extremes: preferring a research scientist over a mass-murderer. Otherwise, there would be no general agreement on the importance of any given criterion.

Lotteries are true to our egalitarian principles, but they expose the arbitrariness of random decisionmaking processes. A queue system appears less arbitrary. "First-come, first-served" is a concept we accept in many other contexts and the existence of a waiting list provides some certainty to the process. Both lotteries and queues, however, produce anomalous results by choosing patients without regard to relative benefit. In its own way, each of these approaches to rationing offends fundamental notions of fairness. Per-

46. *Id.*

47. 5 NATIONAL HEART TRANSPLANTATION STUDY, *supra* note 8, at 44-11.

48. *See infra* notes 59-77 and accompanying text.

49. *See, e.g.*, Reshcer, *The Allocation of Exotic Medical Lifesaving Therapy*, 79 ETHICS 173 (1969); *see also supra* notes 34-37 and accompanying text.

50. Reshcer, *supra* note 49, at 178-79.

51. *See, e.g.*, Childress, *Who Shall Live When Not All Can Live?* in VALUING LIFE, PUBLIC POLICY DILEMMAS 203, 210 (S. Rhoads ed. 1980) ("Ultimately it dulls and perhaps even eliminates the sense of the person's transcendence, his dignity as a person which cannot be reduced to his past or future contribution to society.").

haps the most important reason for rejecting these rationing schemes, however, is that each is explicit—it exposes the fact that we are engaging in rationing, a practice we find discomforting.

While we may be willing to make the necessary budgetary decision to spend less on life-saving technology, such a decision is perceived as having an impact only on "statistical lives." In contrast, when life-saving treatment is withheld from a given individual, we are faced with the death of a known person. Thus, rationing affects "identified lives."[52] The so-called "life-saving imperative"—the belief that "life is priceless"—impels us to do everything possible to save an identified life.[53] Indeed, it is just this notion which poses a risk of what has been labeled "symbolic blackmail"—pressure to increase aggregate resource allocations beyond what they might otherwise be in order to avoid denying medical care to individuals.[54]

3. *Medicare Reimbursement for Heart Transplants—A Recent Attempt at Explicit Government Rationing*

Medicare, the government's single largest health care program, which accounts for projected expenditures of $105 billion by 1988, has been the target of cost cutting at the national level.[55] Medicare provides reimbursement for "reasonable and necessary" medical care.[56] In the past, the Medicare program generally has paid for any treatment ordered by a licensed physician

52. Fried, *The Value of Life,* 82 HARV. L. REV. 1415, 1428-33 (1969); Havighurst & Blumstein, *Coping with Quality/Cost Trade Offs in Medical Care: The Role of PSROs,* 70 NW. U.L. REV. 6, 21-25 (1975).

53. Fried, *supra* note 52, at 1432.

54. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis,* 59 TEX. L. REV. 1345, 1353 (1981). It has been suggested that this "symbolic blackmail" applies with greatest strength to government action. Thus, Professor Blumstein has stated:

> Direct public attempts to contain health care costs, however, risk governmental identification with and responsibility for "every delayable death and preventable hurt." Decentralized choices by nongovernmental decisionmakers such as households, labor unions, insurance companies, hospital committees, and physicians have "greater potential for precluding symbolic concerns from becoming inextricably involved in policy formulation and will likely point more attention to necessary economic tradeoffs."

Id. at 1354 (footnotes omitted). While this may be true, the analysis seems applicable to any system of explicit rationing, especially where the impetus for rationing is a governmental decision to limit health spending. *See infra* notes 102-106 and accompanying text. It is not the fact that rationing is private that avoids symbolic blackmail, but the fact that it is hidden.

55. Arnet, *supra* note 15, at 11.

56. *See* 42 U.S.C. § 1395y(a) (1982) ("no payment may be made under [Medicare part A or B] for any expenses incurred for items or services (1)(A) which . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. . . .").

that is not considered experimental.[57]

In 1979, Medicare regulators faced the issue of extending coverage to heart transplants.[58] Although most private insurance carriers and half of the state Medicaid programs pay for heart transplants,[59] the federal government initially balked at a Medicare extension. No doubt the kidney dialysis experience was fresh in the minds of federal policymakers.[60]

Recognizing the potential for escalating health care costs, the Department of Health and Human Services (HHS), which administers the Medicare program, attempted to put a halt to automatic reimbursement for new treatment technologies. In 1981, HHS commissioned a study by the Battelle Institute to evaluate the safety, efficacy and "social consequences" of "financing the wide distribution" of heart transplants.[61] This study was to "examine all aspects of heart transplants, including the scientific, social, economic, and ethical issues."[62] Presumably, HHS would make the Medicare coverage decision in light of all of the issues addressed in the study.[63] The study was to be the "prototype" for future assessments of emerging medical technology—a kind of "environmental impact statement for medical innovation."[64]

The resulting National Heart Transplantation Study concluded that heart transplant programs were achieving a high rate of success, both in terms of

---

57. In determining whether Medicare will cover a particular treatment, administrators consider whether the treatment is "safe and effective, not experimental, medically necessary, and provided according to accepted standards of medical practice in an appropriate setting." EXECUTIVE SUMMARY, *supra* note 22, at ES-5. For a treatment which is not experimental, the treating physician is generally given discretion to determine which treatment is "reasonable and necessary." *See, e.g.*, Breedon v. Weinberger, 377 F. Supp. 734, 737 (M.D. La. 1974) (physician's decision is not binding but given "great weight"); Reading v. Richardson, 339 F. Supp. 295, 300-01 (E.D. Mo. 1972) (citing legislative history of Medicare statute). *But see* Rendzio v. Secretary of HEW, 403 F. Supp. 917, 919 (E.D. Mich. 1975) (no additional weight given to opinion of plaintiff's physician).

58. EXECUTIVE SUMMARY, *supra* note 22, at ES-1.

59. REPORT OF THE TASK FORCE ON ORGAN TRANSPLANTATION, ORGAN TRANSPLANTATION: ISSUES AND RECOMMENDATIONS, 100, 224 (1986) [hereinafter TASK FORCE REPORT].

60. *See supra* notes 29-47 and accompanying text.

61. EXECUTIVE SUMMARY, *supra* note 22, at ES-8 to -9.

62. *Id.* at ES-6.

63. In March 1980, an administrative law judge ordered Medicare to pay for a heart transplant performed at the University of Arizona, over the objection that it was an experimental procedure. *Id.* at ES-8. One commentator accurately described the dilemma: "Confronted with a dying patient, resource allocation arguments tend to appear bureaucratic, if not academic, to politicians and perhaps to some nonpoliticians as well." Knox, *Heart Transplants: To Pay or Not to Pay*, 209 SCIENCE 570, 574 (1980).

64. Knox, *supra* note 63, at 570.

survival and the quality of life of recipients.[65] Although it was not expressly stated,[66] the study clearly concluded that heart transplantation was no longer an experimental procedure.

In 1984, Congress addressed the growing field of organ transplantation by enacting the National Organ Transplant Act.[67] The National Organ Transplant Act established a Task Force on Organ Procurement and Transplantation to examine the many issues surrounding organ transplantation and to make recommendations to Congress,[68] including recommendations for assuring "equitable access by patients to organ transplantation" and "equitable allocation of donated organs among transplant centers and among patients medically qualified for an organ transplant."[69] The task force made a series of recommendations, including Medicare and Medicaid coverage of heart transplant expenses, as well as, public funding for individuals not covered by Medicare, Medicaid, or private insurance who could not otherwise afford heart transplants.[70]

Thus, HHS faced considerable pressure from Congress and the medical community to cover heart transplants. Although HHS could no longer argue that the procedure was experimental, if all eligible Medicare beneficiaries received heart transplants, the cost could be staggering.[71]

HHS was unable to resist the pressure to provide reimbursement, and in March, 1987, the agency issued a ruling extending Medicare coverage to heart transplants.[72] The natural scarcity of donor hearts, however, eased the potential problems for HHS. Although potential heart transplant recipients number in the tens of thousands, donors number only in the hundreds.[73]

---

65. EXECUTIVE SUMMARY, *supra* note 22, at ES-40 to -56.

66. 1 NATIONAL HEART TRANSPLANTATION STUDY, *supra* note 8, at 1-3. The study did not make a Medicare coverage recommendation.

67. Pub. L. No. 98-507, 98 Stat. 2339 (codified at 42 U.S.C. §§ 273-274e (Supp. III 1985)).

68. 42 U.S.C. § 273 note (Supp. III 1985). The National Organ Transplant Act also prohibited the sale of organs, provided funding for organ procurement agencies and established a national organ-sharing system. 42 U.S.C. §§ 273, 274, 274e (Supp. III 1985).

69. 42 U.S.C. § 273 note (Supp. III 1985).

70. TASK FORCE REPORT, *supra* note 59, at 11.

71. The National Heart Transplantation Study estimated that, in 1979, there were 84,924 Medicare-eligible individuals who died of conditions for which heart transplantation might have been indicated. 2 NATIONAL HEART TRANSPLANTATION STUDY, *supra* note 8 at 13-52, Table 13-28. At $75,000 each, the cost would exceed $6 billion. Even if only 15% of these individuals were medically eligible for transplants, the total cost would approach $1 billion.

72. HCFA Ruling HCFAR 87-1, Medicare and Medicaid Guide (CCH) ¶ 36, 216, at 13, 616 (Apr. 6, 1987) [hereinafter HCFA Ruling].

73. In 1985, 719 heart transplants were performed. TASK FORCE REPORT, *supra* note 59, at 54. The number of donors has been growing steadily. EXECUTIVE SUMMARY, *supra* note 22, at ES-14, Table ES-4.

Because there are so few donor hearts available, transplant programs have applied strict patient selection criteria, including a cut-off for individuals fifty to fifty-five years of age or older.[74] The 1987 HHS ruling essentially adopted these criteria.[75] If only those under age fifty-five are considered eligible, the vast majority of Medicare beneficiaries are excluded.[76] As a result, it is estimated that Medicare will finance only 143 transplants each year by 1991.[77]

Thus, the government effort to explicitly ration heart transplants failed. What the public may not be aware of, however, is that heart transplants are being rationed privately, with government approval, by means of the narrow patient selection criteria.

C. Hidden Rationing

Can we reconcile our conflicting objectives? Can government contain health care costs without adopting an explicit rationing system? Some believe that we can—by avoiding the appearance of rationing, while still accomplishing its objectives.

Respected commentators have suggested that cost containment can best be achieved by government-imposed limits on hospital budgets and ceilings on the amount of medical care that can be provided.[78] Such action would force health care providers to reduce the delivery of medical care by engaging in hidden rationing.

1. Limiting Hospital Budgets—The British System

A study by Aaron and Schwartz describes how a system of budget con-

74. *See infra* text accompanying notes 122-126. According to the National Heart Transplantation Study, in 1980, 14,139 persons under the age of 55 died of conditions for which a heart transplant might have been appropriate. 2 NATIONAL HEART TRANSPLANTATION STUDY, *supra* note 8, at 12-33, Table 12-13. Of the 14,139, the study concluded that 13.7% would be accepted for a transplant under current strict selection criteria. EXECUTIVE SUMMARY, *supra* note 22, at ES-29. *See infra.* note 127.

75. The 1987 HCFA Ruling also implicitly limits the number of hospitals that can participate by imposing minimum standards of experience, staffing, resources and transplant survival rates. HCFA Ruling, *supra* note 72 at 13, 638-39.

76. Generally, Medicare benefits are available only to individuals age 65 or over, and certain disabled individuals. 42 U.S.C.A. § 1395C (West Supp. 1988).

77. *Heart Transplant Costs to Be Paid by Medicare,* N.Y. Times, June 28, 1986, at A6, col. 7.

78. H. AARON & W. SCHWARTZ, THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE (1984); *see also* Blumstein, *supra* note 54, at 1346-56, 1386-92; Eisenberg & Williams, *Cost Containment and Changing Physicians' Practice Behavior,* 246 J. A.M.A. 2195 (1981); Havighurst, Blumstein, & Bovbjerg, *Strategies in Underwriting the Costs of Catastrophic Disease,* 40 LAW & CONTEMP. PROBS. 122 (1976).

straints operates to limit the availability of medical care in Great Britain. Through Great Britain's system of national health insurance, expenditures for all hospitals are limited by a budget established by the national government. Funds are distributed through regions and districts to individual hospitals. Although administrators have discretion in allocating resources, the budget limits inevitably reduce the availability of personnel and equipment.[79]

Physicians in Great Britain must operate within those constraints by selecting some patients for treatment while rejecting others. For example, a hospital may decide it can afford no more than ten kidney dialysis machines. That decision operates to limit the number of patients who can receive dialysis at that hospital. While the British government does not explicitly require rationing or directly establish criteria for selection of patients, budget limits clearly force health professionals to make rationing decisions.[80]

Perhaps the most striking example of the effects of this kind of cost containment is seen in the relative unavailability of kidney dialysis in Great Britain. The proportion of the population undergoing dialysis in the United States in 1980 was more than three times larger than that in the United Kingdom.[81] Unlike the United States, where Medicare reimburses the cost of treatment for everyone, in Great Britain dialysis competes with other types of health care for government financing. The result is that many patients who would be treated in the United States are denied this lifesaving treatment in Great Britain.[82]

---

79. H. AARON & W. SCHWARTZ, *supra* note 78, at 18-20. As Aaron and Schwartz explain:

> The effect of this system is roughly as follows. A hospital is likely to get a budget, adjusted for inflation, that is equal to that of the preceding year unless it can make a persuasive case for a specific additional outlay. If the cost of supplies or wages happens to rise more rapidly than the price index used by the health authorities for adjusting budgets, the hospital administrators and staff must find ways to cut back. Maintenance is an early casualty of restrictions on spending for current operations, with painting cycles, for example, sometimes stretching to decades. Long-term budget control depends on strictly enforced limits on the hiring of physicians, nurses, and other staff. Backlogs of requests for new equipment and replacement of old equipment grow—one piece of radiological equipment in a distinguished London hospital is approaching its golden anniversary. The larger or more experimental the new expenditure, the more likely that the decision about it will be made at a higher jurisdiction, such as the region.

Id. at 19 (footnote omitted).

80. *Id.* at 28, 96.

81. *Id.* at 33.

82. Aaron and Schwartz provide several other examples of areas where budget constraints produce rationing (when compared with levels of consumption in the United States): x-ray examinations, CT scanners, intensive care beds, and coronary artery surgery. *Id.* at 28.

Among the criteria applied in Great Britain to turn away kidney dialysis patients is the presence of other medical diseases. Age, mental illness, and physical handicaps are also considered.[83] Dialysis is rarely available to anyone over the age of fifty-five. In explanation of this common rule of exclusion, the administrator of a large community hospital explained that "[e]veryone over fifty-five . . . is 'a bit crumbly' and therefore not really a suitable candidate for therapy."[84]

2. *Limiting Hospital Spending in the United States—Prospective Payment*

The British system contrasts sharply with our open-ended system of public and private third-party health care financing,[85] through which reimbursement is available for any nonexperimental treatment a physician considers necessary or desirable.[86] The United States system operates to create incentives to provide all available care.[87] As a result, professional standards of care have evolved without consideration of availability or cost.[88] Patients and health professionals alike have come to expect that all beneficial treatment will be provided.[89]

To reduce our health care costs, it is argued, we must alter the practices of providers, since they remain the "gatekeepers" of medical care.[90] One way to accomplish that is to force hospitals to limit the availability of health services, much as the British have done.

Expensive medical technologies are particularly susceptible to this cost cutting. By reducing expenditures on capital equipment and highly specialized staff, hospitals reduce necessarily the availability of services that depend on those resources. This type of cut is easier to accomplish than trying to

---

83. *Id.* at 34.

84. *Id.* at 35.

85. In this country, the vast majority of health care consumers are insulated from the effects of rising prices by private insurance or public health care programs. Comment, *Reagan Administration Health Legislation: The Emergence of a Hidden Agenda,* 20 HARV. J. ON LEGIS. 575, 577 (1983).

86. The Medicare standard of "reasonable and necessary," *see supra* note 56, is generally followed by private insurers, as well. TASK FORCE REPORT, *supra* note 59, at 230.

87. Third-party payment is virtually guaranteed and providing additional care results in additional income to the provider. Comment, *supra* note 85, at 578; Cassel, *Doctors and Allocation Decisions: A New Role in the New Medicare,* 10 J. HEALTH POL., POL'Y & L. 549, 551 (1985).

88. Cassel, *supra* note 87, at 551.

89. *See, e.g.,* Fuchs, *The "Rationing" of Medical Care,* 311 NEW ENG. J. MED. 1572, 1573 (1984); Siegler, *Another Form of Age Discrimination,* 22 ACROSS THE BOARD 8 (1985).

90. Cassel, *Deciding to Forego Life-Sustaining Treatment: Implications for Policy in 1985,* 6 CARDOZO L. REV. 287, 291 (1984); D. MECHANIC, FUTURE ISSUES IN HEALTH CARE: SOCIAL POLICY AND THE RATIONING OF MEDICAL SERVICES 10-11 (1979).

reduce services that can be provided by less specialized hospital personnel with ordinary drugs and supplies because the former has the appearance of simply adjusting to a scarcity, without forcing physicians to deny available care to anyone.[91]

If hospitals are forced to limit expenditures, they may choose to influence physician practices by establishing treatment standards, or protocols, that circumscribe the use of expensive treatments.[92] Given the influence of hospitals over the practices of physicians, it is argued, physicians will change their ways and be more selective in treating individual patients.[93] Even without protocols, physicians will be forced to adjust to limited availability of resources. A physician cannot put a patient in an intensive care unit if no beds are available.

In this country, the federal government does not directly control total health spending or hospital budgets.[94] Nevertheless, it exercises considerable influence through federally supported health care programs.[95] The government's power lies in deciding what treatments it will reimburse and at what level. Further, government influence extends beyond its own programs. For example, where a hospital has assurance that it will be reimbursed by Medicare for providing an expensive technology, it is more likely

91. *See* H. AARON & W. SCHWARTZ, *supra* note 78, at 110. Moreover, *new* technology is an especially good target for cost cutting. The pressure of patient and physician expectations makes it harder to curtail existing coverage or benefits than to deny reimbursement for a new procedure. In contrast, a limitation on the availability of a new technology will not conflict with established professional standards of care. Moreover, as each new technology is developed, third party payors have a built-in opportunity to ration by deciding not to reimburse the costs of its use. Nevertheless, explicit rationing of new technology is difficult, as the example of heart transplants shows. It is inevitable that the new procedure will be compared with those already covered and decisionmakers may be hard pressed to rationalize a distinction supporting noncoverage.

92. Spivey, *The Relation Between Hospital Management and Medical Staff Under a Prospective Payment System*, 310 NEW ENG. J. MED. 984, 984-85 (1984); Note, *Rethinking Medical Malpractice Law in Light of Medicare Cost-Cutting*, 98 HARV. L. REV. 1004, 1014-15 (1985).

93. Hospitals can persuade physicians to conform to established protocols by peer pressure, education or threatened reduction of privileges. Spivey, *supra* note 92, at 985; Note, *supra* note 92, at 1014-15. Physicians also have an interest in seeing that the hospitals with which they are affiliated remain solvent. Spivey, *supra* note 92, at 985.

94. States have more authority to directly control expenditures and capital investment. *See, e.g.*, Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need,"* 59 VA. L. REV. 1143 (1973). Some states, such as Massachusetts and New York, have implemented mandatory controls on the growth of hospital spending. *See, e.g.*, Iglehart, *The New Era of Prospective Payment for Hospitals*, 307 NEW ENG. J. MED. 1288, 1291 (1982).

95. These programs include Medicare, Medicaid, health care provided for veterans through Veterans' Administration hospitals, the Civilian Health and Medical Program of the Uniformed Services for military dependents, and the Indian Health Service.

to make the capital investment necessary to provide the technology.[96]

In 1982 and 1983, Congress enacted legislation altering the system of reimbursing hospitals under Medicare.[97] Reimbursement based on a provider's "reasonable cost"[98] was replaced with a prospective payment system.[99] Under the new system, providers are paid according to a fixed formula based on the diagnosis-related group (DRG) into which the patient's illness falls.[100] The DRG formula is set at a rate expected to cover all services provided by the hospital, including diagnosis and treatment.[101] Regardless of the services actually rendered or the actual length of hospitalization, the hospital will be paid at the fixed rate.

Prospective payment was adopted as a cost cutting measure. As such, it creates incentives to reduce the cost of services available to patients.[102] Only by keeping costs within DRG payment rates can hospitals hope to avoid a financial loss.[103] This has created serious concerns that costs will be cut by

96. HHS approved reimbursement for heart transplants only in facilities which meet stringent criteria. *See supra* note 75. At the same time, facilities are expected to apply those criteria to all heart transplant patients, including those ineligible for Medicare reimbursement. HCFA Ruling, *supra* note 72 at 13,639.

97. Social Security Amendments of 1983, Pub. L. No. 98-21, tit. VI, 97 Stat. 65, 149 (codified in scattered sections of 26 U.S.C. and 42 U.S.C.); Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, tit. I, 96 Stat. 324, 331 (codified in scattered sections of 26 U.S.C. and 42 U.S.C.). This was not the government's first attempt to limit the availability of health services. *See* Comment, *supra* note 85, at 581-82.

98. The Medicare statute provided that "[t]he amount paid to any provider of services . . . with respect to services for which payment may be made under this [title] shall . . . be (1)(A) the reasonable cost of such services . . . ." 42 U.S.C. § 1395f(b) (1982). The necessity and efficiency of costs were not considered. Under the cost-based reimbursement scheme, hospitals had no incentive to hold down costs since they would be reimbursed for all covered health care. Comment, *supra* note 85, at 585-86. As a result, Medicare costs far exceeded projections. In 1970, Medicare costs of $4.95 billion were more than twice the amount originally projected for that year, in the 1965 projections. *Id.* at 580.

99. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601, 97 Stat. 149 (codified in scattered sections of 42 U.S.C.).

100. Comment, *supra* note 85, at 589. There are 467 diagnosis-related groups based on the patient's primary and secondary diagnoses, the patient's age, the primary and secondary procedures used, complications experienced, and concurrent diseases. *Id.* at 590.

101. *Id.* at 587.

102. Cassel, *supra* note 90, at 291; Lave, *Hospital Reimbursement Under Medicare,* 62 MILBANK MEM. FUND Q. 251, 261 (1984).

103. *See* OFFICE OF TECHNOLOGY ASSESSMENT, MEDICARE'S PROSPECTIVE PAYMENT SYSTEM: STRATEGIES FOR EVALUATING COST, QUALITY, AND MEDICAL TECHNOLOGY 100-02 (1985). The Office of Technology Assessment Report notes several ways in which the prospective payment system has the potential to affect access to health care: through effects on the number and distribution of hospital beds, through effects on the admissions policies of hospitals, through effects on the transfer policies of hospitals, and through effects on treatment received after admission to the hospital. *Id.* at 98-105. The Report notes that the system might create financial incentives to hospitals to stop treating certain diagnosis-related groups (DRG) or certain high cost patients (including the "frail elderly" and alcoholics) within a

reducing staff or patient services.[104] The indirect result of this payment system is to reduce the availability of expensive technology. Absent an assurance that they will be reimbursed for its use, hospitals are less likely to invest in expensive equipment and specialized staff.[105] Nevertheless, proponents deny it will have an impact on the quality of care offered to Medicare patients. They contend that prospective payment is simply intended to eliminate waste and inefficiency in the health care delivery system.[106]

Disagreement about whether such restraints will eliminate waste or deny care to those who need it arises from differing views of the propriety of current standards of care. Of course, the severity of the reduction in care will depend on how tightly government pulls the purse strings.[107] It seems clear, however, that the intent of prospective payment, at least in part, is to alter current levels of care.[108] Whether this is considered good or bad policy, it is likely to operate to deny care to individuals who could benefit from it.[109] To that extent, it will result in rationing.

Through this means of cost containment, the government may bring about rationing without mandating it, or even acknowledging that rationing exists. It creates a scarcity that results in hidden rationing by health care providers.

3. *How Hidden Rationing Works*

The kind of hidden rationing that results from resource limits on health care providers has been advocated for several reasons. Using medical criteria as the basis for decisionmaking may avoid the appearance of rationing. Physicians are perceived as simply choosing those for whom treatment is medically suitable.[110]

---

given DRG. *Id.* at 99. Where hospitals continue to treat all patients, they might adopt a practice of differential treatment of Medicare and other patients. *Id.* at 102.

104. *See, e.g.*, Brown, *The Rationing of Hospital Care* in 2 SECURING ACCESS, *supra* note 8, at 253, 277; Cassel, *supra* note 87, at 553; Comment, *supra* note 85, at 594.

105. *See supra* note 79.

106. *See, e.g., Hospital Prospective Payment System: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance,* 98th Cong., 1st Sess. 17 (1983) (statement of Secretary of Health and Human Services Richard Schweiker); Comment, *supra* note 85, at 588.

107. Mild budget limits might do no more than "subject hospitals to some of the cost discipline that competitive businesses routinely face, but from which hospitals are sheltered by present methods of reimbursement [by] squeez[ing] out pure waste and reduc[ing] amenities for patients and staff." H. AARON & W. SCHWARTZ, *supra* note 78, at 123. The problem with mild limits, however, is that savings would be small. *Id.*

108. Spivey, *supra* note 92, at 984-85.

109. H. AARON & W. SCHWARTZ, *supra* note 78, at 122; *cf.* Hadley, *How Should Medicare Pay Physicians?,* 62 MILBANK MEM. FUND Q. 279, 280-81 (1984) ("If fiscal pressures dictate that Medicare spend less for physician services . . . then any changes made to meet that objective will result in reductions in either beneficiary access to care and/or quality of that care.").

110. This kind of rationing system has the potential for creating a financial conflict between

Indeed, British experience suggests that physicians are expected to rationalize the limitations placed on them by resource constraints. By redefining professional standards of care, physicians can advise patients that they are receiving all appropriate care.[111] To avoid difficult choices, physicians may welcome the development of hospital treatment protocols on which they can rely.[112] Thus, the rationing which is hidden within the medical decisionmaking process could avoid the "symbolic blackmail"[113] associated with other forms of rationing because it preserves the fiction that everything of medical value is being done for the individual patient.

This kind of rationing scheme results largely in "aresponsible allocation" of health care because the decisionmakers are not publicly accountable.[114] Selection standards may not be articulated, but, even where they are, they are not acknowledged as rationing standards. Moreover, the notion that any inquiry will interfere with the practice of medicine protects the decisionmaking process from scrutiny.[115]

Hidden rationing is advocated because it hides from public scrutiny the "explicit ordering of sensitive priorities and overt interpersonal comparisons,

---

providers and patients, causing "a fundamental shift away from the traditional physician-patient relationship based on trust and agency." Hadley, *supra* note 109, at 286-87. Some have warned against altering the role of the physician as patient advocate. *See, e.g.*, Fried, *Rights and Health Care—Beyond Equity and Efficiency*, 293 NEW ENG. J. MED. 241, 242 (1975).

111. Aaron and Schwartz describe the means by which British physicians deal with the shortage of kidney dialysis services.

> Confronted by a person older than the prevailing unofficial age cutoff for dialysis, the British GP tells the victim of chronic renal failure or his family that nothing can be done except to make the patient as comfortable as possible in the time remaining. The British nephrologist tells the family of a patient who is difficult to handle that dialysis would be painful and burdensome and that the patient would be more comfortable without it; or he tells the resident alien from a poor country that he should return home, to be among family and friends who speak the same language—where, as it happens, the patient will die because dialysis is unavailable.
>
> . . . .
>
> In each instance physicians are asserting that the treatment is *medically* optimal or very close to optimal, that patients denied care or provided alternative forms of care because of budget limits lose essentially nothing of medical significance. For the undialyzed patient with renal failure who dies, . . . this view is unpersuasive even if the underlying judgment that resources must be limited is correct. But it enables doctors to avoid the painful realization that they are doing less than the best for the patient.

H. AARON & W. SCHWARTZ, *supra* note 78, at 101.

112. "[M]edical practice is characterized by considerable uncertainty as to the amount of care necessary." D. MECHANIC, *supra* note 90, at 98. If we are going to ask physicians to ration medical care, uniform standards should be adopted.

113. *See supra* note 54 and accompanying text.

114. Mehlman, *supra* note 32, at 274-75.

115. *See, e.g.*, Havighurst & Blumstein, *supra* note 52, at 57.

which are bound to have demoralizing effects in an egalitarian democratic society."[116] Advocates of such a rationing scheme contend that avoiding government involvement eliminates the kind of legal scrutiny that can seriously impede the whole rationing process.[117]

Nevertheless, rationing, even by physicians, is still rationing. Medical decisionmaking requires an evaluation of a patient's need for treatment and its probable success or futility. When decisionmakers go beyond this determination, however, to establish priorities for treatment, they are not making a medical decision, but, rather, a social policy decision. That decision may be based upon medical efficacy, that is, choosing the patient with the best chance of survival, or it may be based upon other criteria of social utility, but it is still rationing.[118]

4. Heart Transplants: An Example of Hidden Rationing

The patient selection criteria for heart transplants demonstrate the problems inherent in rationing by medical criteria. Generally, patients are deemed eligible if they have a critical medical need for a transplant, meaning that they have little likelihood of surviving more than six months without a transplant. Generally, these individuals are invalids for whom no other treatment is expected to be successful.[119] However, because the number of patients who qualify under these strict criteria exceeds the supply of donor hearts, further screening is necessary and physicians must ration among prospective patients.

When the HHS commissioned the National Heart Transplantation Study,[120] it published suggested eligibility criteria, developed by the National Heart, Lung, and Blood Institute,[121] for prospective heart transplant patients. Although the criteria vary, hospitals that perform heart transplants generally consider the following conditions to be contraindications to treatment:[122]

---

116. *Id.*

117. Blumstein, *supra* note 54, at 1356-85.

118. It may be necessary to apply medical criteria about need and prospects of success even when making a policy decision. That fact may operate to obscure the distinction between medical and policy decisionmaking. For example, only a physician, applying medical criteria, can choose patients with the best chance of survival.

119. 46 Fed. Reg. 7072, 7073 (1981).

120. *See supra* notes 61-66 and accompanying text.

121. 46 Fed. Reg. 7072, 7073-74 (1981).

122. Of the six transplant programs participating in the national study, five explicitly included an age cut-off of 50 or 55 in their patient selection criteria. *See* 1 NATIONAL HEART TRANSPLANTATION STUDY, *supra* note 8, at 8-18 (Columbia-Presbyterian Medical Center), 8-31 (Medical College of Virginia), 8-50 (University of Minnesota), 8-58 (University of Pittsburgh), 8-66 (Stanford University Medical Center).

1. Advancing age, beyond the age (usually fifty or fifty-five) at which the "individual begins to have diminished capacity to withstand postoperative complications."[123]

2. Comorbid conditions, including severe pulmonary hypertension, severe liver or kidney dysfunction, active systemic infection, recent pulmonary infarction, insulin-requiring diabetes mellitus, significant peripheral or cerebrovascular disease, acute peptic ulcers, or any other systemic disease "likely to limit or preclude survival and rehabilitation after transplantation."[124]

3. History of a behavior pattern (including drug or alcohol addiction) or psychiatric illness "likely to interfere significantly with compliance with a disciplined medical regimen."[125]

4. "Absence of adequate external psychosocial supports for either short or long-term."[126]

Physicians undoubtedly would describe all of the patient selection criteria for heart transplants as medical criteria because they are designed to produce a successful clinical outcome.[127] For example, some of the "comorbid conditions" are considered disqualifying because a patient who has one of these conditions may be unable to survive a transplant or the use of immunosuppressive drugs, which are necessary to avoid rejection of the trans-

123. 46 Fed. Reg. 7072, 7073 (1981).

124. *Id.* at 7074.

125. *Id.*

126. *Id.*

127. The use of these criteria is reinforced by the adoption of HHS Medicare reimbursement requirements. The HHS ruling adopts essentially the same patient selection criteria. HCFA Ruling, *supra* note 72, at 13,641. Among the "strongly adverse factors" is "advancing age." The ruling states:

> a. Strongly adverse factors include: (1) Advancing age; for example, a patient beyond 53 to 57 years of age (the mid 50's). Until not long ago, limited experience with patients over age 50 showed that these patients had both impaired capacity to withstand post-operative immunosuppressive complications and lessened survival. More recently, carefully selected patients through age 55 have had good survival experience: but experience with patients beyond age 55 is limited. The selection of any patient for transplantation beyond age 50 must be done with particular care to ensure an adequately young "phsysiologic" age and the absence or insignificance of coexisting disease.

Id. Although these are characterized as guidelines, hospitals which select patients who fall "far outside" the selection criteria will not be eligible for Medicare funding. *Id.* at 13,625. Those who do not meet all the criteria are not considered "suitable transplant candidate[s]." *Id.* Use of the criteria is reinforced by reporting requirements. *Id.* at 13,639. Moreover, because hospitals must achieve a one and two year actuarial survival rate of 73% and 65% respectively, *id.* at 13,638-39, 13,627, hospitals have a strong incentive to use these narrow selection criteria. Indeed, HHS expects these criteria to apply to all patients, including those ineligible for Medicare reimbursement. *Id.* at 13,639.

plant.[128] Behavioral history and "external psychosocial supports," such as the support of family, friends, employer, and co-workers, are considered relevant to the patient's ability to adapt to the necessary alterations of lifestyle, including adherence to a strict diet, a medication regimen, and other restrictions.[129]

Although the published patient selection criteria are medical criteria, they do more than identify those for whom a heart transplant is a medically suitable treatment: they provide a basis for choosing among those individuals. To identify those for whom a transplant is medically indicated, the physician would ask only whether the benefits to a certain patient outweigh the risks of treatment. With patients who are estimated to live no longer than six months without a transplant, and who choose to undergo the complex surgery and aftercare, the answer would seem to be that anyone whose life can be extended for a substantial period of time would benefit.[130]

Beyond this, however, the criteria seem to reflect social worth considerations. By utilizing age and "potential for rehabilitation" after transplantation, they seem to favor those patients who are expected to live longer and have a higher "quality of life."[131] While the medical profession considers them to be criteria of medical suitability for treatment,[132] the criteria also seem to embody certain social value judgments.[133]

---

128. 46 Fed. Reg. 7073-74 (1981).

129. *Id.* at 7074.

130. Indeed, no one suggests that every individual who fails to meet the established profile will be unable to survive a transplant. If more donor hearts were available, or if the artificial heart became a viable alternative to human heart transplantation, purely medical criteria would necessarily expand eligibility. *See* EXECUTIVE SUMMARY, *supra* note 22, at ES-102.

The kidney dialysis experience demonstrates that medical criteria respond to considerations of availability and funding. In 1972, there were 10,000 patients on kidney dialysis; over the years, the number has risen to 78,000. In significant part, this is due to a relaxation of selection criteria, so that dialysis is provided to older and sicker patients. For example, before 1972, only seven percent of dialysis patients were over 55. By 1978, more than 45% were over 55. *Id.* at ES-103, Table ES-26.

131. According to the Task Force on Organ Transplantation, the "prevailing ethos and practice are to allocate organs to the recipient who will live the longest with the highest quality of life." TASK FORCE REPORT, *supra* note 59, at 87.

132. The American Medical Association has stated its position on rationing: "Limited health care resources should be allocated efficiently and on the basis of fair, acceptable, and humanitarian criteria. Priority should be given to persons who are most likely to be treated successfully or have long term benefit. Social worth is not an appropriate criterion." AMERICAN MEDICAL ASSOCIATION, ALLOCATION OF HEALTH RESOURCES, OPINION 2.02, CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION 2 (1982). Thus, physicians may not distinguish clearly between medical and social worth criteria.

133. An unstable behavioral or psychological history (including alcoholism and drug addiction) and the absence of external psychosocial supports would seem to reflect other social

The British experience[134] should warn us that social worth criteria may appear in the guise of medical criteria. This nation's experience with kidney dialysis demonstrates that there is little medical justification for excluding those over age fifty five and those who are mentally ill from kidney dialysis.[135] Similarly, the heart transplant criteria may reflect considerations other than medical efficacy. Moreover, it is easy to see that an aresponsible decisionmaking process increases the chances that the decisionmakers' personal value judgments come into play.[136] The medical and social worth considerations may overlap and be difficult to distinguish. Thus, hidden rationing by health care providers does not eliminate the problems evident in other forms of rationing.

5. Older Persons: Likely Targets of Hidden Rationing

Older persons seem particularly susceptible to efforts at rationing.[137] There is an intuitive basis for concluding that an older person has less chance of achieving a successful clinical outcome. Thus, it may be relatively easy for some to accept the notion that, as the British doctor expressed it, as we get older we all get "a bit crumbly"[138] and, therefore, are at greater risk in undergoing medical treatment. Furthermore, to the extent that we attempt to cut costs by reducing efforts that prolong the process of dying,

---

worth considerations. The latter criterion, especially, can be expected to disfavor members of certain economic and social groups.

A recent study compared the population of hemodialysis patients in 1967, before Medicare coverage of dialysis, with the number of hemodialysis patients in 1978, after coverage was extended. It found that although blacks constituted 24% of those with end stage renal disease, they represented only seven percent of the hemodialysis population in 1967. By 1978, although blacks still constituted 24.1% of those with end stage renal disease, the number of blacks receiving dialysis rose dramatically to 34.9%. Evans, Blagg & Bryan, *supra* note 19, at 488-89.

134. *See supra* notes 79-84 and accompanying text.

135. After Medicare began paying for kidney dialysis, the percentage of patients over 55 rose to 45.7%, indicating that they were considered medically eligible. EXECUTIVE SUMMARY, *supra* note 22, at ES-103.

136. *See* Mehlman, *supra* note 32, at 258; Note, *supra* note 30, at 662.

137. This analysis may be equally true of the handicapped who may be adversely affected by rationing decisions based upon anticipated "quality of life." One of the primary reasons for enactment of the antidiscrimination provisions of the Rehabilitation Act, 29 U.S.C. § 794 (1982), was to protect against society's willingness to accept unproven generalizations about the capacities of the handicapped. The Baby Doe cases are one example. *See supra* notes 1-3 and accompanying text. Moreover, there is evidence that physicians have allocated intensive care resources based upon evaluation of continued ability to interact meaningfully with others. Mulley, *The Allocation of Resources for Medical Intensive Care, in 3* SECURING ACCESS, *supra* note 8, at 185, 302. This Article focuses on the elderly, however, because they represent a much larger percentage of the population and of health care costs.

138. *See supra* text accompanying note 84.

some may choose to start with the elderly because they are more likely to see illnesses of the aged in those terms.[139]

At the same time, there is a certain rationality to reserving scarce health care resources for those who hold jobs, have young families, and have their "whole lives ahead of them." Aaron and Schwartz viewed this as an explanation for the bias against care of the elderly in the British system.[140] Although painfully frank, Colorado Governor Richard Lamm's suggestion that the terminally ill who are old should die and get out of the way of the young[141] may reflect a widely accepted view of resource allocation.

Moreover, the characteristics of the elderly render them a prime target for rationing medical care. As a group, they are sicker and require more expensive care. Indeed, their treatment costs are largely responsible for spiraling health care expenditures. Because medical and social policy reasons for using age as a patient selection criterion overlap, the elderly are likely targets of health care rationing.

6. *Examining Rationing Decisions*

The true nature of the patient selection criteria for heart transplants, and similar criteria for other medical procedures, cannot be determined without subjecting such criteria to critical scrutiny. One opportunity for such scrutiny is through legal challenge. Proponents of hidden rationing contend that the standards are not open to broad scale legal inquiry because they involve only private action within the generally protected area of medical practice.[142] In reaching that conclusion, however, those proponents have overlooked an area of federal law that is directly applicable to private decisionmaking by hospitals—the federal civil rights laws.

---

139. *See* Siegler, *supra* note 89, at 10.

140. H. AARON & W. SCHWARTZ, *supra* note 78, at 96-97.

141. *Gov. Lamm Asserts Elderly, If Very Ill, Have 'Duty to Die'*, N.Y. Times, Mar. 29, 1984, at A16, col. 5.

142. Professor Blumstein contends that individual patients will be adequately protected from unfair treatment by state tort law. Blumstein, *supra* note 54, at 1395-1400. This is far from clear.

There are three ways in which a rationing decision to deny medical care could result in tort liability. First, a physician who refuses treatment or discharges a patient prematurely without affording him or her an opportunity to obtain alternative care may be found to have committed the intentional tort of abandonment. *See, e.g.*, Spendlove v. Georges, 4 Utah 2d 392, 295 P.2d 336 (1956), Hall v. Nagel, 139 Ohio 265, 39 N.E.2d 612 (1942).

Second, concealing from a patient the availability of a treatment may expose the physician to a claim of tortious failure to obtain the patient's informed consent. *See, e.g.*, Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Truman v. Thomas, 27 Cal. 3d 285, 165 Cal. Rptr. 308, 611 P.2d 902, (1980).

Third, a physician will be liable in a malpractice action if he or she fails to exercise due care, that is, the degree of care customarily exercised by members of the medical profession. *See* W.

The remainder of this Article will discuss the Age Discrimination Act of 1975 (ADA) and its impact on the use of age as a patient selection criterion. Because age is currently being used as a rationing criterion for heart transplants, the analysis will focus on whether that use can survive scrutiny under the ADA.

II. THE AGE DISCRIMINATION ACT OF 1975

The ADA[143] is modeled after title VI of the Civil Rights Act of 1964, which broadly prohibits discrimination on the basis of race, color, and national origin in programs and activities supported with federal financial assistance.[144] Title VI had its origin in the notion that "simple justice" requires that funds of the United States, derived from the tax dollars of citizens of all races, should not be used to support racial discrimination.[145] Since its passage, that basic philosophy has been extended to prohibit discrimination on the basis of sex through the Education Amendments of 1972,[146] on the basis of handicap through section 504 of the Rehabilitation Act of 1973[147] and, on the basis of age through the ADA.

Section 6102 of the ADA provides: ". . .no person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving federal financial assistance."[148] While the ADA employs prohibi-

---

PROSSER, HANDBOOK OF THE LAW OF TORTS 162-64 (4th ed. 1971). Under that standard, if rationing becomes customary, the physician who rations may not be considered negligent.

The doctrines of abandonment and informed consent also seem to rely upon customary standards of care. That is, a physician would not be liable for failing to provide treatment or information which is not customarily provided by physicians. Of course, changes in custom are gradual and in the transition period there may be inconsistent rulings on malpractice liability.

Some states have adopted a more stringent standard of accepted or expected practice. *See, e.g.*, Darling v. Charleston Community Memorial Hosp., 33 Ill. 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966); Blair v. Eblen, 461 S.W.2d 370 (Ky. 1970). This standard would make it more difficult to defend rationing.

Tort law seems to be based on the assumption that it is customary practice to provide all beneficial care. For that reason, it is not readily adaptable to a rationing situation.

143. 42 U.S.C. §§ 6101-6107 (1982).

144. 42 U.S.C. §§ 2000d to 2000d-6. Section 601 contains the prohibitory language which is the essence of title VI: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 42 U.S.C. § 2000d.

145. *See* 119 CONG. REC. 6544 (1964) (remarks of Sen. Humphrey); *id.* at 6561 (remarks of Sen. Kuchel).

146. 20 U.S.C. § 1681 (1982).

147. 29 U.S.C. § 794 (1982).

148. 42 U.S.C. § 6102 (1982). The coverage of the Age Discrimination Act (ADA) is lim-

tory language identical to that of title VI, the analogy is not complete. Unlike title VI, the ADA contains several broad exceptions to the basic prohibition. This difference reflects a congressional understanding that while distinguishing among individuals on the basis of race is always unfair, "age may often be a reasonable distinction."[149]

The ADA contains two exemptions from coverage. Section 6103(b)(2) provides an exemption for "any program or activity established under authority of any law" which "provides any benefits or assistance to persons based upon the age of such persons" or "establishes criteria for participation in age-related terms or describes intended beneficiaries or target groups in such terms."[150] In addition, section 6103(c) excludes most employment practices.[151] With the exception of programs receiving financial assistance under the Comprehensive Employment and Training Act of 1974, regulation of age discrimination in employment was left to the Age Discrimination in Employment Act of 1967.[152]

There are also three exceptions to the ADA's basic prohibition against age discrimination. Section 6103(b)(1) provides that action otherwise prohibited by section 6102 does not violate the Act when:

"(A) such action reasonably takes into account age as a factor necessary to [1] the normal operation or [2] the achievement of any statutory objective of such program or activity; or (B) the differentiation made by such action is

---

ited to programs and activities receiving federal financial assistance. *See infra* text accompanying notes 332, 334.

149. H.R. CONF. REP. NO. 670, 94th Cong., 1st Sess. 56, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1321, 1323 [hereinafter 1975 1975 CONFERENCE REPORT].

150. 42 U.S.C. § 6103(b)(2). The original implementing regulations adopted by the Department of Health, Education, and Welfare (HEW) interpreted this provision to exempt age distinctions contained in any federal, state or local statute or ordinance adopted by an elected, general purpose legislative body. 45 C.F.R. § 90.3(b)(1) (1987). At the same time, the Department rejected the argument that age distinctions authorized by regulations should also be exempt. 44 Fed. Reg. 33,772 (1979) (codified at 45 C.F.R. pt. 90). *See infra* note 252 and accompanying text.

151. Section 6103(c) provides:

> (1) Except with respect to any program or activity receiving Federal financial assistance for public service employment under the Job Training Partnership Act (29 U.S.C.A. § 1501 et seq.), nothing in this chapter shall be construed to authorize action under this chapter by any Federal department or agency with respect to any employment practice of any employer, employment agency, or labor organization, or with respect to any labor-management joint apprenticeship training program.
>
> (2) Nothing in this chapter shall be construed to amend or modify the Age Discrimination in Employment Act of 1967 (29 U.S.C. §§ 621-634), as amended, or to affect the rights or responsibilities of any person or party pursuant to such Act.

42 U.S.C.A. § 6103(c) (West 1983 & Supp. 1988).

152. 29 U.S.C. §§ 621-634 (1982).

based upon reasonable factors other than age."[153]

Congressional ambivalence about the propriety of differentiating among program beneficiaries on the basis of age is evident in the legislative history of the ADA. Despite scant evidence of the existence of age discrimination, Congress made clear its belief that the problem was sufficient to warrant a legislative solution. At the same time, its broadly worded exceptions validate many age distinctions.[154]

One might normally look to the legislative history for guidance in separating the permissible from the impermissible uses of age distinctions under the statute. Unfortunately, Congress appears never to have faced up to that difficult task. Nevertheless, the legislative history does reveal that Congress was particularly concerned with the discriminatory use of certain age distinctions when it enacted the ADA.

A. Passage of the Age Discrimination Act of 1975

The ADA was enacted in 1975 as part of the Older Americans Amendments of 1975, an omnibus bill providing a broad range of programs for the elderly.[155] The idea of barring age discrimination in federally assisted programs seems to have originated with Arthur S. Flemming, the influential former Secretary of the Department of Health, Education and Welfare, now known as the Department of Health and Human Services. Dr. Flemming simultaneously held the positions of HEW Commissioner on Aging and Chairman of the United States Commission on Civil Rights in 1975. In testimony before a subcommittee of the House Education and Labor Committee, which, early in 1975, was considering reauthorization of the Older Americans Act of 1965, Dr. Flemming condemned "ageism"—implying that, along with racism and sexism, it was pervasive in this country.[156]

Although the House hearings included no further discussion of the subject, the bill reported by the House committee contained a ban on age dis-

153. 42 U.S.C. § 6103(b)(1).

154. It is not the purpose of this Article to address whether the existence of age discrimination justified passage of legislation. Rather, this Article identifies the problem Congress sought to reach and suggests that the statute be interpreted in light of that original concern.

155. The Older Americans Amendments of 1975, Pub. L. No. 94-135, 89 Stat. 713, (codified at 42 U.S.C. §§ 3001-3057g (1982)), reauthorized and modified a set of programs for the elderly, ranging from nutrition services to community service employment, originally adopted in the Older Americans Act of 1965, Pub. L. No. 89-73, 79 Stat. 218 (codified at 42 U.S.C. §§ 3001-3056 (1982)).

156. H.R. REP. NO. 67, 94th Cong., 1st Sess. 15 (1975). Dr. Flemming expressed his "hope that the day will come when the Civil Rights Act will be amended to include age as well as sex" discrimination. *Id.*

crimination.[157] The House report pointed out the "non-involvement of older persons" as workers and volunteers which, the committee concluded, was often the result of "deep-seated prejudice against the elderly."[158] That prejudice, the report continued, served to deny the elderly opportunities "solely because they have reached a given age" and without consideration of the "merits of each case."[159]

The report noted also that "prejudices against the aged" are reflected in the failure to provide older persons with their "fair share" of services in the areas of health, education, and transportation.[160] For specific examples of age discrimination, the report relied on two White House conferences on aging and the passage of the Age Discrimination in Employment Act.[161] The House report concluded that it was "clear . . . that discrimination against old persons is still widespread."[162]

The bill passed the House with little debate.[163] Although it prohibited age discrimination in federally assisted programs, the hearings and debate had done little to identify the need for such a prohibition, and even less to explain the scope of that prohibition.

In the Senate, Dr. Flemming testified before a subcommittee of the Senate Committee on Labor and Public Welfare. There, he supported the need for legislation by reference to cases of age discrimination in employment.[164] He went on to detail what he considered to be the under-representation of older persons in federally assisted service programs, including community health centers, community mental health centers, rehabilitation programs, social services, legal services, education programs, employment programs, and revenue sharing.[165] Dr. Flemming attributed this under-representation, which had been cited in the House committee report, to discrimination and stated that "[b]ecause older people are viewed as being less able to find employment or unable to work, they are not provided services or sought out as program participants."[166]

157. H.R. 3922, 94th Cong., 1st Sess. title III (1975); *see* H.R. REP. NO. 67, 94th Cong., 1st Sess. 32 (1975).

158. H.R. REP. NO. 67, 94th Cong., 1st Sess. 15 (1975).

159. *Id.*

160. *Id.*

161. *Id.* at 16.

162. *Id.*

163. *See, e.g.*, 121 CONG. REC. 9212 (1975) (remarks of Rep. Brademas); *id.* at 9231 (remarks of Rep. Solarz); *id.* at 9217 (remarks of Rep. Randall).

164. *Legislation to Extend the Older Americans Act: Hearings Before the Subcomm. on Aging of the Senate Comm. on Labor and Public Welfare on S. 1425*, 94th Cong., 1st Sess. 389 (1975).

165. *Id.* at 390-91.

166. *Id.* at 390.

Although the Senate subcommittee reported a bill similar to that which had passed the House, the full committee was more reluctant.[167] Then HEW Secretary Caspar Weinberger had written to the committee expressing the Administration's serious reservations about the legislation. Weinberger cautioned that the House bill "would leave to the Executive Branch . . . momentous policy decisions in wholly uncharted areas without the benefit of any specific legislative guidance."[168] He went on to raise a number of questions about the scope of the statutory exceptions.[169]

Weinberger's letter had an influence on the Senate committee.[170] In its report, the committee expressed the need for more information to determine "the causes, scope, nature, and extent of age discrimination in federally assisted programs" so that the "need for additional legislation . . . can be fairly and reasonably assessed."[171] The bill reported out of committee and passed by the Senate[172] replaced the prohibition on age discrimination with direc-

---

167. The Senate subcommittee had approved a bill almost identical to that which passed the House. S. REP. NO. 255, 94th Cong., 1st Sess. 13, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1252.

168. Letter from Caspar W. Weinberger to Harrison A. Williams (June 18, 1975); S. REP. NO. 255, 94th Cong., 1st Sess. 37, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1278.

169. The letter stated:

> Neither the bill nor its legislative history indicates what factors would be "reasonable." Even a very preliminary review of the potential ramifications suggests a myriad of unexplored issues such as the following:
>
> Is it "reasonable" for school systems to exclude three-year-olds from kindergarten classes? Or eleven-year-olds from high school classes?
>
> Can a medical or dental school bar a 50-year-old person from taking one of its limited classroom seats because his or her life expectancy suggests a practice of relatively brief duration?
>
> Is it "reasonable" to limit reduced-fare or free public transportation to those age 65 or over?
>
> Can existing guaranteed housing loans and senior citizen housing programs be limited to specific age groups?
>
> At what age would a person be deemed to be sufficiently mature to consent to sterilization, to receive family planning information or to elect specific medical treatment?

S. REP. NO. 255, 94th Cong., 1st Sess. 37-38, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1278-79.

170. On the Senate floor, Senator Eagleton stated that the committee had been influenced by "the seriousness of the concerns expressed" in Secretary Weinberger's letter. 121 CONG. REC. 21,172 (1975).

171. S. REP. NO. 255, 94th Cong., 1st Sess. 32, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1272. The Senate Committee did not reject the conclusion that there was age discrimination in federally assisted programs. Indeed, it stated that there was "some evidence that older persons are unreasonably discriminated against" and expressed concern about reports of discrimination in access to educational institutions and mortgages. *Id.*

172. S. 1425, 94th Cong., 1st Sess. § 301 (1975).

tions to the Civil Rights Commission to conduct a one-year study of the problem.

In conference, negotiations bogged down over the two very different versions of the title which was to become the ADA, threatening passage of the entire Older Americans Act.[173] Eventually, the conferees arrived at an awkward "compromise": they would combine both the House and Senate approaches. The final legislation prohibited discrimination and mandated a study to determine the extent and nature of that discrimination.[174]

The conference did nothing to clarify the standard to be applied in scrutinizing age distinctions under the legislation. However, it did make one change. The conference amended the statement of purpose enunciated in section 6101 to add the term "unreasonable." Thus, the announced purpose of the ADA was to prohibit not all age discrimination, but only that which was "unreasonable."[175] It is far from clear that this added anything to the statute's meaning. Although the Conference Report noted that the operative prohibitory language of section 6102 was to be "modified by considerations of reasonableness,"[176] the actual language of section 6102 did not incorporate that term. Instead, the basic prohibition was modified by the statutory exceptions.[177] The scope of those exceptions was never explained.

Although the conferees recognized the importance of resolving these issues, they acknowledged that there was no "clear consensus" among the members of Congress on which age-based distinctions would violate the ADA.[178] While the conference report candidly admitted the existence of "basic differences on the extent to which age may validly be taken into account"[179] in determining eligibility for federally assisted programs, the legislative history is so sparse that the different views cannot even be identified. Indeed, there is no evidence that any member of Congress seriously tried to

173. *See* 121 CONG. REC. 37,735 (1975) (remarks of Sen. Eagleton).

174. 1975 CONFERENCE REPORT, *supra* note 149, at 54-59, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1321-26.

175. Pub. L. No. 94-135, § 302, 89 Stat. 713, 728 (1975) (codified at 42 U.S.C. § (1982)); *see also* 1975 CONFERENCE REPORT, *supra* note 149, at 54, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1321.

176. 1975 CONFERENCE REPORT, *supra* note 149, at 56, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1323.

177. *Id.*, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1323. For a discussion on the standard applicable to the principal normal operation exception, see *infra* notes 258-90 and accompanying text.

178. 1975 CONFERENCE REPORT, *supra* note 149, at 56, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1323.

179. *Id.*, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1323.

address the complex definitional issues.[180]

Senator Eagleton described the problem:

> I share the concern of the Members of the House, who supported these provisions so strenuously, that there may be otherwise qualified individuals who are denied access to such programs solely because of their age, but I could never get satisfactory answers to certain fundamental questions, such as "Which programs? In what numbers? Who decides what age discrimination is unreasonable?"
>
> This last question of reasonableness is of the utmost importance, Mr. President, for unlike race discrimination, age discrimination is not per se arbitrary. Our laws commonly make distinctions among individuals based upon their age, often for the purpose of defining those eligible for a particular kind of Government benefit, such as social security, or for describing the target group for a particular piece of legislation, just as this bill is designed to aid older Americans. So it is not all age discrimination that we want to prohibit, but only that which is unreasonable.
>
> And what is unreasonable age discrimination? Whatever it is cannot be determined from the bill, for it simply prohibits "unreasonable age discrimination" and tosses the ball to the executive branch to determine what is reasonable and unreasonable.[181]

Instead of resolving these "fundamental" policy questions[182] before enacting the ADA, the conferees agreed on two provisions which they hoped would lead to its resolution. First, as discussed above, they directed the Civil Rights Commission to undertake a study identifying current examples of "unreasonable" age discrimination in federally assisted programs and to obtain the views of interested parties, including federal agencies, on the reasonableness of age-based distinctions in such programs.[183] Second, they provided that the Act would not be self-executing, but would be effectuated by federal agency regulations and enforced only by fund termination and other

---

180. The only exception was Representative Quie, who provided some explanation for the "statutory objective" exception:

> Thus, in a bill providing grants for the improvement of reading in the elementary grades, but for which a relatively small sum had been appropriated, the decision could be made to concentrate the effort on the first three grades even though this discriminates against older children. The basis of the decision would be that otherwise the objective of the program would be defeated.

121 CONG. REC. 37,299 (1975).

181. *Id.* at 37,735.

182. 1975 CONFERENCE REPORT, *supra* note 149, at 57, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1324.

183. 42 U.S.C. § 6106 (1982).

means of agency enforcement pursuant to those regulations.[184]

The statute established a timetable whereby the prohibitory provisions would not become effective until January 1, 1979,[185] after the Civil Rights Commission completed its report and agency regulations were issued.[186] Postponement of the effective date was intended to give Congress the opportunity to reexamine the ADA after the Commission issued its report and before enforcement began.[187] The Older Americans Act was due to expire in 1978 and it was anticipated that consideration of the ADA could be undertaken as part of the reauthorization process.

B. The 1978 Amendments

When Congress reexamined the statute in 1978, it reaffirmed the need for the ADA by retaining the statute largely intact. It failed, however, to clarify the standard to be applied in interpreting its provisions.

In January, 1978, the Civil Rights Commission issued its report on age discrimination.[188] Based on its study of ten federally assisted programs,[189] the Commission made findings and a number of recommendations.

For purposes of its study, the Commission defined age discrimination as "any act or failure to act, or any law or policy that adversely affects an

184. Although some provision was made for judicial review, the statute, in 1975, contained no authorization of a private right of action, or pattern and practice suits by the Attorney General. *Id.* at §§ 6102, 6103. The House version of the legislation did contain these provisions. 1975 CONFERENCE REPORT, *supra* note 149, at 57, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1324. By striking these provisions, Congress intended that the law be implemented through "a set of consistent Federal regulations rather than on a case by case method in the courts." *Id.*, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1324.

185. 42 U.S.C. § 304(a)(5); *see also* 1975 CONFERENCE REPORT, *supra* note 149, at 57, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1324. In 1978, the effective date was changed to July 1, 1979 to provide Congress more time to consider amendments to the existing statute. *See* Comprehensive Older Americans Act Amendments of 1978, Pub. L. No. 95-478, § 401(b)(2), 92 Stat. 1513, 1555 (codified as amended at 42 U.S.C. § 6103(a)(5) (1982)).

186. *See* 42 U.S.C. §§ 6103, 6106.

187. 1975 CONFERENCE REPORT, *supra* note 149, at 57, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1324.

188. UNITED STATES COMMISSION ON CIVIL RIGHTS, THE AGE DISCRIMINATION STUDY, PART I (1977) [hereinafter STUDY I]. In January 1979, the Commission issued a second volume describing the study's methodology and summarizing the record of information obtained about each of the federal programs studied. UNITED STATES COMMISSION ON CIVIL RIGHTS, THE AGE DISCRIMINATION STUDY, PART II (1979) [hereinafter STUDY II].

189. The programs included community mental health centers, legal services, basic vocational rehabilitation services, community health centers, social services to individuals and families (title XX of the Social Security Act), training and public service employment (CETA), food stamps, Medicaid, state basic vocational education grants, and adult basic education. STUDY I, *supra* note 188, at 4-7. The Commission also examined the undergraduate and graduate admission policies at institutions of higher education. *Id.* at 7-8.

individual on the basis of age."[190] The study was further guided by the "principle that administrators of Federally assisted programs have a duty to take steps to ensure that eligible persons have the opportunity to participate in all programs regardless of their age."[191] Given these basic principles, it is, perhaps, not surprising that the study found that age discrimination was "widespread" and "[p]ersons aged 65 or over [were] consistently adversely affected."[192] The study made no effort to apply the statutory definitions as expressed in the basic prohibition of section 6102 and exceptions of section 6103, nor did it examine the statute's effect on existing federally assisted programs.

The study showed underrepresentation of the elderly in each program, based largely upon a methodology that compared program participation rates for the elderly against their percentage of the total population in the area served by the program. For example, persons over sixty-five comprised 9.9% of the service area population of all community mental health centers. That age group, however, represented only 4.1% of the new patients served by the centers in 1975.[193]

Some underrepresentation was attributed to lack of trained staff or inadequate outreach efforts.[194] There were also examples of the explicit use of age distinctions. The study pointed to some evidence of staff biases against older people.[195] For the most part, however, the Commission found that priorities set by program administrators caused the low participation rates. For example, programs to train individuals for employment were targeted toward younger people who had a better chance of securing employment and who would be expected to work for a greater number of years.[196] Some community mental health centers did not expand services or outreach efforts for the elderly because they considered the probability of successfully treating older persons less than it was for younger patients.[197]

Of the 114 medical schools surveyed, twenty-eight schools specified age restrictions as part of their selection process.[198] Among the explanations

190. STUDY I, *supra* note 188, at 3.

191. *Id.* at 2.

192. *Id.* at 3. The study found that other age groups were adversely affected in some programs. For example, children under 15 were underserved by the community mental health centers program. *Id.* at 11. However, persons over 65 were found to be the "most frequently affected age group." *Id.* at 10. The study noted that generally "the older an individual, the more likely he or she will be the victim of age discrimination." *Id.*

193. *Id.* at 11.

194. *Id.* at 52-56, 74-76.

195. *Id.* at 71-74.

196. *Id.* at 30-33, 61-66, 68-69.

197. STUDY II, *supra* note 188, at 93-95.

198. STUDY II, *supra* note 188, at 181.

given by the Association of American Medical Colleges was that medical school requires seven to ten years of expensive training. Thus, "the investment by society in educating physicians is so great that the proportional reduction in practicing years makes older candidates a less worthwhile societal investment."[199] The study reported one extreme example of a state Medicaid program which "routinely" denied prior approval for nonemergency surgery to older persons on the grounds that the "investments would not be cost effective for the [s]tate" because the surgery would not be expected to result in an increase in taxable income or a decrease in welfare payments.[200]

Thus, where resources were limited, program administrators often targeted their services to younger persons in an effort to "provide society with the greatest return on its investment."[201] The Civil Rights Commission condemned this cost-benefit rationale as inconsistent with the "concept of the dignity and worth of the individual."[202]

The major recommendation of the report was, perhaps, compelled by the broad definition of age discrimination used by the Commission. The report recommended amending the statute to prohibit the use of age as a criterion for eligibility in federally assisted programs except where specifically authorized by federal legislation or where "taken to overcome the effects of conditions which resulted in limiting participation by persons of a particular age."[203] The Commission felt that neither state legislators nor federal, state, or local program administrators should be permitted to introduce age distinctions where not authorized by federal statute.[204]

The Commission theorized that it is never reasonable to utilize age as a criterion for allocating benefits under federally assisted programs because other criteria are available by which to evaluate "the relative needs of individuals."[205] Although it might be more administratively convenient to use age as a proxy for those other criteria, in the Commission's view that alone would not justify the exclusion of individuals based upon generalizations about age.[206]

In early 1978, the House subcommittee held hearings on the Commis-

199. *Id.* at 190 (quoting *Hearing Before the U.S. Commission on Civil Rights,* 12 (Washington, D.C., Sept. 26-28, 1977) (statement of Dr. J. Sherman, Ass'n of American Medical Colleges)).

200. *Id.* at 265-68.

201. STUDY I, *supra* note 188, at 79.

202. *Id.*

203. *Id.* at 88.

204. *Id.* at 85-86.

205. *Id.* at 83.

206. *Id.*

sion's report.[207] Dr. Flemming, the first witness, presented the Commission's report and urged adoption of its recommendations.[208] After the conclusion of Dr. Flemming's prepared testimony, Representative Jeffords posed a question: "Would it be improper . . . to utilize as professional criteria the worth of the individual to society based upon the likely life of that person?" Dr. Flemming responded that he did not believe "that we have the competence to sit in judgment of our fellow human beings in that particular manner."[209]

After further hearings, the House committee reported, and the House passed, a bill reauthorizing the Older Americans Act. The bill would have implemented the Commission's major recommendation by making two amendments to the ADA: (1) deleting the term "unreasonable" from the statutory statement of purpose, and (2) severely narrowing the exceptions contained in section 6103 to permit the use of age as a program criterion only when authorized by federal statute or undertaken to overcome the effects of conditions limiting past participation.[210]

The Senate had already passed a bill reauthorizing the Older Americans Act without any amendments to the ADA.[211] Although the Senate had insisted on the Commission study, it never held hearings after the study was completed. The earlier questions about the need for the legislation appeared to have evaporated.[212] Indeed, only the Administration seemed concerned about the Commission's report and recommendations. Although administrations had changed since passage of the original legislation, the opposition of the executive branch continued.[213]

---

207. *Oversight on the Age Discrimination Act of 1975 and Extension of the Older Americans Act of 1965: Hearings Before the Subcomm. on Select Education of the House Comm. on Education and Labor,* 95th Cong., 2d Sess. (1978) [hereinafter *1978 Hearings*]. A number of witnesses testified in favor of the ADA and the Commission's recommendations, but none offered further evidence of age discrimination or of a need to amend the statute. *See, e.g., id.* at 193-225 (testimony of Jack Ossofsky, Executive Director of the National Council on the Aging); *id.* at 420-37 (testimony of Robert J. Ahrens, President of the Urban Elderly Coalition); *id.* at 556-88 (testimony of Rep. Claude Pepper).

208. *Id.* at 2-25 (testimony of Arthur S. Flemming, Chairman of the U.S. Commission on Civil Rights).

209. *Id.* at 23 (testimony of Rep. James Jeffords).

210. H.R. 12,255, 95th Cong., 2d Sess. § 401 (1978); *see* H.R. REP. NO. 1150, 95th Cong., 2d Sess. 40 (1978).

211. S. 2850, 95th Cong., 2d Sess.; *see* S. REP. NO. 855, 95th Cong., 2d Sess. (1978).

212. In introducing the House hearings, Rep. Brademas, Chairman of the Subcommittee on Select Education, stated that the ADA had been "enacted in response to evidence of pervasive and unconscionable age discrimination in our society." *1978 Hearings, supra* note 207, at 1.

213. As required by statute, 42 U.S.C. § 6106(e), the Department of Health, Education and Welfare (HEW) prepared a response to the Commission's study, and the response was submitted to the White House and congressional committees. It was critical of the Commission's

After the bills had been sent to conference, the Administration took steps to defeat the provision in the House bill that would have narrowed the section 6103 exceptions. Then HEW Secretary Joseph Califano wrote to the conferees expressing opposition to any change in the exceptions and exclusions.[214]

For a second time, a conference considering the ADA produced a strange "compromise." The term "unreasonable" was deleted from the statement of purpose, but the amendment to section 6103 was dropped. Whatever purpose the conferees may have had in striking the term "unreasonable" from the statement of purpose, that amendment effected no substantive change in the statute.[215] Clearly, Congress had rejected the Commission's definition of prohibited discrimination. Although the Commission sought to prohibit all age distinctions with an adverse effect, that could have been accomplished only by amending the substantive standards of section 6102 and section 6103.[216]

"assumptions and methodology" and opposed any change in existing exceptions to the ADA. Schuck, *The Graying of Civil Rights Law: The Age Discriminat ion Act of 1975,* 89 YALE L.J. 27, 55-56 (1979).

214. Letter from Secretary Califano to conferees on Older Americans Act amendments (Sept. 12, 1978), *quoted in* Schuck, *supra* note 207, at 57 n.159. For a discussion of the Administration's role in the defeat of the House amendment, see *id.* at 55-57.

215. At most, the amendment can be read as an affirmation that the statutory exceptions should not be governed by a "reasonableness" test. Representative Claude D. Pepper explained his understanding of the amendment:

> The present exemptions are retained, but I believe that the deletion of the word "unreasonable" from the act's statement of purpose gives a good indication of how Congress intends the existing exemptions to be interpreted. The ADA must be viewed as a civil rights statute. As such, exceptions to it must be narrowly construed. I am particularly concerned with certain excuses for not serving older people put forward by program managers interviewed by the Civil Rights Commission in preparing its report. They include the so-called cost-effectiveness argument, which asserts that, since it is often more expensive to reach older clients, a program could reasonably conclude that it could concentrate on younger persons. Other managers argue that the existence of age-specific programs, such as the community service employment program for older Americans, justifies other, more general programs, such as those funded under the Comprehensive Employment and Training Act, ignoring the needs of older applicants.
>
> Mr. Speaker, these excuses are nothing more than that. The deletion of the word ["unreasonable"] from the statement of purpose makes that clear. Such practices are discriminatory. They will be prohibited under the new amendments.

124 CONG. REC. 33,487 (1978).

216. The only other significant amendment made in 1978 involved private actions to enforce the ADA. A private right of action had been provided in the House version of the 1975 legislation. Section 307 of H.R. 3922 provided that any aggrieved person could obtain judicial review pursuant to the Administrative Procedures Act. That provision had been struck in conference and the legislation which passed provided that agency fund terminations and "other means authorized by law" were to be the exclusive means of enforcement. 1975 CON-

C. The Intent of Congress

Although the legislative history of the 1975 Act and the 1978 Amendments is largely ambiguous and uninformative, certain conclusions can be drawn. First, Congress believed that the problem of age discrimination in federally assisted programs was sufficient to warrant a remedy. The factual basis for the enactment of age discrimination legislation can be found in two sources: the Civil Rights Commission report and the legislative history of the Age Discrimination in Employment Act.

Despite some initial skepticism about the need for legislation, the ADA never faced any real congressional opposition. Although the purpose of the Civil Rights Commission study was to explore the need for a statute barring age discrimination, when Congress reviewed the findings of the study in 1978, no effort was made to repeal the statute. Thus, it is logical to assume that Congress considered the evidence of discrimination revealed by the study sufficient to demonstrate that a statutory remedy was needed. The Commission's findings, however, were influenced by its sweeping definition of age discrimination,[217] a definition Congress clearly rejected when it declined to adopt the Commission's proposed amendment to the statutory exceptions in section 6103.

What then was the discrimination that Congress was trying to prohibit? The answer is far from clear. Perhaps it was not politically feasible for Congress, having passed a prohibition on age discrimination, to repeal that legislation and, thereby, appear to favor such discrimination.

There is, however, another answer to this seeming contradiction. Congress may have been impressed by the Commission's factual findings without being willing to adopt its legal conclusions. Although Congress was not ready to join the Commission in characterizing all age distinctions with an adverse effect on the elderly as unlawful discrimination, the Commission provided a factual basis for concluding that the elderly had been the victims of intentional discrimination.

The Commission report contained some evidence that older individuals were being excluded from important education and training opportunities and that their medical needs were being overlooked.[218] Moreover, these re-

---

FERENCE REPORT, *supra* note 149, at 53, 55, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1320, 1321.

In 1978, the House bill provided a private action by striking the section limiting remedies. H.R. REP. NO. 1150, 95th Cong., 2d Sess. 40, 125 (1978). It also provided for the award of reasonable attorney's fees to the prevailing party. *Id.* The House provisions were retained in conference and became § 6104(e) of the amended ADA. 42 U.S.C. § 6104(e) (1982).

217. *See supra* note 190 and accompanying text.

218. *See supra* notes 193-98 and accompanying text.

sults were attributed to a widespread attitude that program resources should be targeted toward younger individuals because providing services to the elderly would bring the lowest return on the government's investment.[219] Members of Congress may have differed on the reasonableness of the justifications given for this kind of priority setting. The failure of Congress to repeal the statute, however, must be read as indicating an intent to prohibit at least some of the conduct identified by the Commission study.

Moreover, the House committee report's reference[220] to the Age Discrimination in Employment Act (ADEA)[221] was significant. In 1965, the Secretary of Labor reported to Congress that despite "basic research in the field of aging [establishing] that there is a wide range of individual physical ability regardless of age,"[222] there "is persistent and widespread use of age limits in hiring."[223] The report concluded "that in a great many cases [the use of age limits] can be attributed only to arbitrary discrimination against older workers on the basis of age and regardless of ability."[224] Age discrimination was based largely upon "stereotypes unsupported by objective fact" and rarely upon the sort of animus motivating racial discrimination.[225] Such discrimination was found to be pervasive, affecting hundreds of thousands of workers.[226]

Further study of the problem by Congress confirmed the Secretary's findings.[227] In 1967, Congress enacted the ADEA[228] "to prohibit arbitrary age discrimination in employment" against workers age forty through sixty-five[229] and "to promote employment of older persons based on their ability

219. *See supra* note 201 and accompanying text.

220. H.R. REP. NO. 67, 94th Cong., 1st Sess. 16 (1975).

221. 29 U.S.C. §§ 621-634 (1982).

222. REPORT OF THE SECRETARY OF LABOR, THE OLDER AMERICAN WORKER: AGE DISCRIMINATION IN EMPLOYMENT 9 (1965); EQUAL EMPLOYMENT OPPORTUNITY COMMISSION (EEOC), LEGISLATIVE HISTORY OF THE AGE DISCRIMINATION IN EMPLOYMENT ACT 26 (1981).

223. REPORT OF THE SECRETARY OF LABOR, *supra* note 222, at 21; EEOC, *supra* note 222, at 37.

224. REPORT OF THE SECRETARY OF LABOR, *supra* note 222, at 21; EEOC, *supra* note 222, at 37; *see also* 113 CONG. REC. 31,256-57 (1967) (remarks of Sen. Young); *Age Discrimination in Employment: Hearings on Age Discrimination Bills Before the Subcomm. on Labor of the Senate Comm. on Labor and Public Welfare,* 90th Cong., 1st Sess. 22 (1967).

225. *See* EEOC v. Wyoming, 460 U.S. 226, 231 (1983).

226. H.R. REP. NO. 805, 90th Cong., 1st Sess. 2, *reprinted in* 1967 U.S. CODE CONG. & ADMIN. NEWS 2213-14 (quoting President Johnson's message of Jan. 23, 1967).

227. *See* EEOC v. Wyoming, 460 U.S. at 230-31 (citations omitted).

228. Pub. L. No. 90-202, 81 Stat. 602 (1967) (codified as amended at 29 U.S.C. §§ 621-634 (1982)).

229. 29 U.S.C. § 621(b). The Age Discrimination in Employment Act (ADEA) was amended in 1978 to protect individuals aged 40 through 69. *Id.* § 631(a).

rather than age."[230] This evidence apparently convinced Congress of a need for further legislation to prevent discrimination in all federally assisted programs.

Second, although the ADA was intended to protect all age groups,[231] Congress was primarily concerned with prohibiting discrimination against older individuals.[232] The reports and debates repeatedly refer to discrimination against the elderly.[233] There is virtually no mention of other age groups. The ADEA protects only those above the age of forty. Even the Commission report includes few examples of unfair treatment of other age groups.[234]

Third, Congress did not generally condemn the use of age distinctions in the ADA. A sweeping provision exempts all age distinctions authorized by law.[235] Indeed, Congress' real difficulty was in drawing a line between the impermissible and the permissible. Nevertheless, there are certain indications of what it considered impermissible.

By modeling the ADA after the ADEA, Congress sought to prohibit in federally assisted programs the same kind of discrimination prohibited under the ADEA. The ADEA was passed to prevent the unnecessary use of untested generalizations about older individuals to deny them employment opportunities. By citing the evil identified in the ADEA,[236] Congress emphasized its intent to prohibit the same evil from depriving older persons of important benefits under federally assisted programs. And Congress sought to accomplish that result in the same way—by applying a standard to test the accuracy and necessity of using age-based generalizations. Thus, it modeled the primary "normal operation" and "statutory objective" exceptions of the ADA after a similar provision in the ADEA.[237]

Given this purpose, it seems equally clear that Congress wished to prevent the establishment of maximum age limits for participation in federally assisted programs when those limits were based upon an assessment of the "social worth" of older individuals. The rationale that older persons should

230. *Id.* § 621(b) (statement of findings and purpose).

231. *See, e.g.*, H.R. REP. NO. 67, 94th Cong., 1st Sess. 16 (1975).

232. 44 Fed. Reg. 33,771-88 (1979) (HEW regulations).

233. *See, e.g.*, H.R. REP. NO. 67, 94th Cong., 1st Sess. 16 (1975); 121 CONG. REC. 9212 (1975) (remarks of Rep. Brademas).

234. Indeed, it has been suggested that the Commission report did not even demonstrate that children were participating in the federal programs it examined at a lower rate than adults. *See* Teitlebaum, *The Age Discrimination Act and Youth*, 57 CHI.[-]KENT L. REV. 969, 984-91 (1983).

235. *See supra* notes 149-50 and accompanying text.

236. *See supra* notes 219-30 and accompanying text.

237. *See* text accompanying *infra* note 259.

be excluded from programs because they will live fewer years and, therefore, provide society a lower return on its investment was condemned specifically in the 1975 House report,[238] as well as the Commission report[239] and Dr. Flemming's testimony.[240]

Even more important, this longevity rationale, if taken to its logical conclusion, would threaten to undermine the very intent of the statute. The conclusion that older individuals are likely to live fewer years is a valid generalization. The statute does not condemn it because it is irrational, but because it could be used to justify any maximum age limit for participation in a federally assisted program. It seems unlikely that Congress would seek to prohibit untested generalizations about the elderly and, yet, permit this longevity rationale to survive.

The ADA was part of the Older Americans Act, a statute providing a wide variety of benefits to the elderly.[241] The very existence of this and similar statutes and government programs belies the notion that Congress would have been willing to accept the conclusion that the elderly have a diminished social value.

Fourth, Congress avoided the difficult definitional issues, choosing instead to vest considerable discretion in HEW and other federal agencies to define the prohibited conduct as it applied to their particular programs. Aside from identifying congressional concern with the uses of age distinctions described above, the legislative history is not revealing. Ultimately, the scope of the ADA will be judged by the statutory language and its administrative interpretation.

D. The HEW Regulations

In June 1979, HEW issued general, governmentwide regulations[242] that were to serve as the model for all other agency regulations, as called for by section 6103 of the ADA. The HEW regulations had the force and effect of law, giving effect to the statutory prohibition of section 6102.[243] Section

238. *See supra* note 210 and accompanying text.
239. *See supra* note 202 and accompanying text.
240. *See supra* note 209 and accompanying text.
241. *See supra* note 155 and accompanying text.
242. 44 Fed. Reg. 33,768 (1979).
243. Section 6102 provides:

> *Pursuant to regulations* prescribed under section 6103 of this title, and except as provided by section 6103(b) and section 6103(c) of this title, no person in the United States shall, on the basis of age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity receiving Federal financial assistance.

42 U.S.C. § 6102 (1982) (emphasis added).

6103 directed HEW to promulgate general, governmentwide regulations "to carry out the provisions of section 6102."[244] Thereafter, each agency that extended federal financial assistance was to issue regulations governing its own programs. Those regulations were to be consistent with the general HEW regulations and would not become effective without the approval of the Secretary of HEW.[245]

The legislative history indicates that Congress considered these regulations central to the statutory scheme.[246] Federal departments and agencies, under the leadership of HEW, were to provide definition to the statutory standards. Against that background, it is likely that a court would uphold

---

244. Section 6103(a) reads, in part:

> (1) Not later than one year after the transmission of the report required by section 6106(b) of this title, or two and one-half years after November 28, 1975, whichever occurs first, the Secretary [of Health and Human Services (then Health, Education and Welfare)] shall publish in the Federal Register proposed general regulations to carry out the provisions of section 6102 of this title.
>
> (2) (A) The Secretary shall not publish such proposed general regulations until the expiration of a period comprised of—
>
> (i) the forty-five day period specified in section 6106(e) of this title, and
>
> (ii) an additional forty-five day period, immediately following the period described in clause (i), during which any committee of the Congress having jurisdiction over the subject matter involved may conduct hearings with respect to the report which the Commission is required to transmit under section 6106(d) of this title, and with respect to the comments and recommendations submitted by Federal departments and agencies under section 6106(e) of this title.
>
> (B) The forty-five day period specified in subparagraph (A)(ii) shall include only days during which both Houses of the Congress are in session.
>
> (3) Not later than ninety days after the Secretary publishes proposed regulations under paragraph (1), the Secretary shall publish in the Federal Register final general regulations to carry out the provisions of section 6102 of this title, after taking into consideration any comments received by the Secretary with respect to the regulations proposed under paragraph (1).
>
> . . . .
>
> (5) Notwithstanding any other provision of this section, no regulations issued pursuant to this section shall be effective before July 1, 1979.

42 U.S.C. § 6103.

245. Section 6103(a)(4) provides:

> (4) Not later than ninety days after the Secretary publishes final general regulations under paragraph (a)(3), the head of each Federal department or agency which extends Federal financial assistance to any program or activity by way of grant, entitlement, loan, or contract other than a contract of insurance or guaranty, shall transmit to the Secretary and publish in the Federal Register proposed regulations to carry out the provisions of section 6102 of this title and to provide appropriate investigative, conciliation, and enforcement procedures. Such regulations shall be consistent with the final general regulations issued by the Secretary, and shall not become effective until approved by the Secretary.

42 U.S.C. § 6103(a)(4).

246. 1975 CONFERENCE REPORT, *supra* note 149, at 57, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1324.

the regulations, enforcing them absent a clear inconsistency with the language or manifest intent of the statute.[247]

The use of an age test to exclude an individual from a federally assisted program can be upheld only if it comes within one of the statutory exceptions or exemptions of section 6103. Of the five exceptions and exemptions, this Article will focus on the one most relevant to rationing medical care—the normal operation exception. Before turning to that exception, however, a brief discussion of another provision—the "any law" exemption—is appropriate.

E. The "Any Law" Exemption

Section 6103(b)(2) of the ADA provides:

> The provisions of this chapter shall not apply to any program or activity established under authority of any law which (A) provides any benefits or assistance to persons based upon the age of such persons; or (B) establishes criteria for participation in age-related terms or describes intended beneficiaries or target groups in such terms.[248]

An age distinction which qualifies under this provision is automatically exempt and not subject to further testing under the other statutory exceptions.[249]

---

247. *See, e.g.*, Commissioner of Internal Revenue v. Portland Cement Co., 450 U.S. 156, 169 (1981); Chrysler Corp. v. Brown, 441 U.S. 281, 301-06 (1979); Batterton v. Francis, 432 U.S. 416 (1977); National Ass'n of Pharmaceutical Mfrs. v. FDA, 637 F.2d 877 (2d Cir. 1981); 2 K. DAVIS, ADMINISTRATIVE LAW TREATISE § 7.8 (2d ed. 1979 & Supp. 1982).

Great care was taken in formulating the original HEW regulations. In addition to the usual steps of notice and comment prior to the issuance of regulations, HEW went to considerable lengths to obtain the views of those who might be knowledgeable about the effect the proposed regulations would have on federal programs. It created an interagency task force composed of members from all federal agencies which administer programs of federal financial assistance, distributed more than 16,000 copies of the proposed rules to members of Congress, state governors, administrators of federally assisted programs, recipients of federal funds at the state and local levels and other interested individuals and groups, and held extensive public hearings around the country. 44 Fed. Reg. at 33,768-69 (1979).

248. 42 U.S.C. § 6103(b)(2) (1982).

249. The language would seem to exempt any program or activity established under authority of any law which employs an age distinction. This provision cannot be interpreted literally without producing anomalous results. For example, a statute may provide grants for adult education programs for those over age 18. Under a literal construction, any program administered pursuant to such a grant could use other age distinctions in its program (like excluding all individuals over the age of 50) and its action would not be subject to the ADA because it is part of a program or activity established under authority of a law which provides benefits on the basis of age. Obviously, Congress intended to approve only those age distinctions which were authorized by law. The HEW general regulations correctly adopted the latter construction. 45 C.F.R. § 90.3(b)(1) (1987).

It is clear that Congress wished to exempt age distinctions contained in federal statutes.[250] In interpreting the meaning of "any law," there are two further questions: 1) Does the exemption apply to regulations as well as statutes; and 2) Does the exemption embrace state and local law? The legislative history provides virtually no guidance on these crucial issues.[251]

HEW, in its general regulations, considered the several possible interpretations and concluded that "any law" did not cover regulations, but that it did incorporate state and local laws. "Law," according to the regulations meant "statute or ordinance adopted by an elected, general purpose legislative body."[252] HEW chose a reasonable interpretation of the statutory language and legislative history, although it certainly was not the only possible interpretation.[253]

The regulations explained that inclusion of state and local laws within the exception "recognizes the authority of State and general purpose, elected local governments to enact statutes which condition benefits or participation on the basis of age."[254] Thus, HEW concluded that just as Congress must have the discretion to draw age distinctions, so must other legislative bodies.

The agency chose a very practical approach. Pursuant to its police power, a state or locality may set a minimum age for drinking, obtaining a driver's license, or owning a firearm. It may make age distinctions in its penal statutes, athletic programs, and recreational activities. Additionally, it may grant special tax relief or transportation discounts to the elderly. These distinctions are commonplace and generally noncontroversial. There is no reason to believe that Congress sought to disturb the numerous state and local laws which incorporate age distinctions.[255] Certainly, nothing in the legislative history even remotely indicates an intent to reach these laws.

---

250. The 1975 Conference Report explained the addition of clause (B) which extends the exemption to the use of "age-related terms." The report noted that the House bill, without clause (B), limited the exclusion of "programs for which the law provides benefits to persons based on such person's age, such as with Social Security." 1975 CONFERENCE REPORT, *supra* note 149, at 58, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1325.

251. To the extent that the legislative history is at all helpful, it indicates that "any law" was not meant to include regulations. The 1975 Conference Report stated that the conferees had "basic differences on the extent to which age may validly be taken into account by program administrators in determining who is eligible to participate in programs, in the absence of *statutorily-established* criteria regarding age." 1975 CONFERENCE REPORT, *supra* note 149, at 56, *reprinted in* 1975 U.S. CODE CONG. & ADMIN. NEWS 1325 (emphasis added); *see also* 121 CONG. REC. 37,299 (1975) (remarks of Rep. Quie) (ADA "does not apply to reasonable and necessary distinctions based upon age, or to distinctions which are made pursuant to statute or necessary to the achievement of a statutory objective.").

252. 45 C.F.R. § 90.3(b)(1) (1987).

253. *See* Schuck, *supra* note 213, at 58-63.

254. 44 Fed. Reg. 33,772 (1979).

255. Of course, even if they were not excluded, these age distinctions could be reached

At the same time, this exemption sweeps broadly. Its scope is not limited to the noncontroversial or benign uses of age distinctions. It would have been unthinkable to include such an exemption in title VI or the other statutes barring discrimination in federally assisted programs. To do so would have permitted the very discrimination which the statutes were designed to prohibit.

HEW, however, provided a basis for drawing a distinction between the ADA and those statutes. Although the other statutes were largely directed at discrimination by states and localities, HEW found no "clear indication that age discrimination occurs as a result of State and local statutes."[256]

This conclusion seems questionable. There had been examples of states and localities discriminating against older individuals in employment. Indeed, the ADEA was amended in 1974 to cover state and local governmental entities for just that reason.[257] Nevertheless, it was reasonable for HEW to exclude states and localities without some clear expression by Congress that it intended to cover them.

The "any law" exemption is quite significant for two reasons. It narrows the scope of the statute considerably. But it also moderates the impact of the statutory prohibition and exemptions. If any age distinction is struck down, it can be validated by the passage of federal, state, or local legislation. If a legislative body makes a policy choice to permit an age distinction in a given program, the ADA will not be a barrier. Clearly, this should alleviate some concern about an overly strict application of the statute.

The "any law" exemption reveals Congress' ambivalence about the use of age distinctions. It is difficult to understand how an age distinction can be discriminatory when adopted by program administrators and not discriminatory when enacted by legislators. Perhaps the rationale for accepting legislative use of age distinctions, while subjecting others to scrutiny, is found in the process by which an age distinction is adopted. The legislative use of an age distinction authorized by this exemption is always explicit, open to public scrutiny, and often adopted only after public debate. In contrast, when an age distinction is adopted by a program administrator, the potential beneficiary of the program may not even know that he or she was excluded because of age. Nor does public scrutiny necessarily precede the adoption of any age test by a federally assisted program. While public scrutiny does not

---

under the ADA only insofar as they were applied by a program or activity receiving federal financial assistance. *See infra* text accompanying notes 332, 334.

256. *Id.*

257. Fair Labor Standards Amendments of 1974, Pub. L. No. 93-259, § 28(a)(1)-(4), 88 Stat. 55, 74 (codified as amended at 29 U.S.C. § 630(b) (1982)); *see also* EEOC v. Wyoming, 460 U.S. 226, 233 (1983).

eliminate the possibility that age will be used in an arbitrary manner, it does provide some protection. Congress apparently did not consider age discrimination so pervasive that the majoritarian process could not be trusted to protect the minority's rights.

F. The Normal Operation Exception

A federally assisted program may use age as a criterion for participation, even though such action would otherwise violate the basic statutory prohibition of the ADA, if that action "reasonably takes into account age as a factor necessary to the normal operation or the achievement of any statutory objective of such program or activity."[258] This exception is governed by a standard of "reasonable necessity."

1. The ADA's Normal Operation Exception is Analogous to the ADEA's Bona Fide Occupational Qualification Exception

The language of the normal operation exception in the ADA is very similar to an exception found in the ADEA. The ADEA prohibits employment practices that discriminate, on the basis of age, against individuals between

258. 42 U.S.C. § 6103(b)(1)(A). The "statutory objective" language of this provision applies only to uses of age in programs conducted pursuant to statute, while the normal operation language also applies to Federally assisted programs that do not operate pursuant to federal statute, such as private medical schools. Statutory programs may be able to rely on the normal operation exception, but only to the extent that the program's normal operation is not inconsistent with its statutory objective.

Congress added the statutory objective language in conference, in 1975, without any explanation of its meaning, except for a brief remark by Representative Quie. *See supra* note 180. Presumably, Congress recognized that programs conducted pursuant to statute must be governed by the objectives of that statute and the use of age should be evaluated in terms of those objectives.

The HEW general regulations apply the same four-part test to both the normal operation and statutory objective exceptions. 45 C.F.R. § 90.13 (1987). This seems reasonable in light of the statutory context. Both exceptions are modified by the same language ("such action reasonably takes into account age as a factor necessary"), which provides the basis for the standard. Professor Schuck would apply a different standard to the statutory objective exception, largely on the basis of "unofficial" legislative history and Representative Quie's remarks. *See* Schuck, *supra* note 213, at 73-76. The HEW regulations seem reasonable enough to withstand challenge.

The regulations are more vulnerable, however, in defining statutory objectives to include only a purpose "expressly stated in" a federal, state or local statute. While this is a reasonable requirement for the "any law" exemption, it is not for the statutory objective exception. Often statutes have implicit objectives, revealed only in the legislative history or inferred from the statutory scheme. These purposes should be given weight in deciding whether a particular use of age is necessary to achieve a statutory objective. For purposes of this article, reference to the normal operation exception encompasses the statutory objective exception as well.

the ages of forty and sixty-nine.[259] The ADEA creates an exception, however, permitting an employer to utilize age as an employment criterion when age constitutes a "bona fide occupational qualification reasonably necessary to the normal operation of the particular business" (BFOQ).[260]

The ADEA's BFOQ provision was interpreted by the Supreme Court in *Western Air Lines, Inc. v. Criswell.*[261] Western Air Lines had a rule requiring retirement of flight engineers at age sixty, which it sought to justify as necessary to the safe operation of its aircraft.[262]

The medical testimony in the case was conflicting. Western's expert witness testified that "with advancing age the likelihood of onset of disease increases and that in persons over age 60 it could not be predicted whether and when such diseases would occur."[263] At the same time, plaintiffs' experts testified that "physiological deterioration is caused by disease, not aging, and that 'it was feasible to determine on the basis of individual medical examinations whether flight deck crew members, including those over age 60, were

259. The basic prohibition against discriminatory employment practices is found in 29 U.S.C. § 623 (1982). Section 623(a) declares it unlawful for an employer:

> (1) to fail or refuse to hire or to discharge any individual or otherwise discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual's age;
>
> (2) to limit, segregate, or classify his employees in any way which would deprive or tend to deprive any individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual's age; or
>
> (3) to reduce the wage rate of any employee in order to comply with this chapter.

Id. § 623(a). There are also provisions respecting the activities of employment agencies and labor organizations. *Id.* § 623(b)-(c). These provisions are similar to § 703 of title VII of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, religion, sex, and national origin. 42 U.S.C. § 2000e-2 (1982).

260. 29 U.S.C. § 623(f)(1). The bona fide occupational qualification (BFOQ) exception of the ADEA was modeled after the BFOQ exception of title VII which permits classifications based on religion, sex, or national origin "where religion, sex, or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of that particular business or enterprise." 42 U.S.C. § 2000e-2(e)(1).

261. 472 U.S. 400 (1985).

262. *Id.* at 403. For certain commercial flights, Western requires three crew members in the cockpit: a captain, a first officer or co-pilot and a flight engineer. The flight engineer does not operate the flight controls unless the captain and first officer become incapacitated. *Id.*

A regulation of the Federal Aviation Administration (FAA) prohibits any person over the age of 60 from serving as a pilot or first officer on a commercial flight. 14 C.F.R. § 121.383(c) (1988). The FAA rule has been justified on the theory that "incapacitating medical events" and "adverse psychological, emotional, and physical changes" occur as a consequence of aging. "The inability to detect or predict with precision an individual's risk of sudden or subtle incapacitation, in the face of known age-related risks, counsels against relaxation of the rule." 49 Fed. Reg. 14,695 (1984). The FAA has specifically refused to establish a mandatory retirement age for flight engineers. 49 Fed. Reg. 14,694 (1984).

263. *Criswell,* 472 U.S. at 406 (quoting Criswell v. Western Air Lines, Inc., 514 F. Supp. 384, 390 (C.D. Cal. 1981)).

physically qualified to continue to fly.' "[264] Western contended that such medical disputes were inevitable, and juries should not be "permitted 'to resolve bona fide conflicts among medical experts respecting the adequacy of individualized testing.' "[265] Therefore, Western argued, its determination of safety requirements should be accepted so long as it was supported by reasonable expert opinion.[266]

The Court squarely rejected Western's argument, emphasizing that reasonable necessity, not reasonableness, was the standard Congress had adopted for the BFOQ exception.[267] According to the Court, a rule requiring deference to the employer's expert "would allow some employers to give free reign to the stereotype of older workers that Congress decried in the legislative history of the ADEA."[268]

The Court noted that the purpose of the ADEA was "to promote employment of older persons based on their ability rather than age."[269] Moreover, generalizations about the "psychological and physiological degeneration" caused by aging had been rejected by Congress, in favor of an individualized determination of ability.[270] The BFOQ provision was a limited exception to that general understanding, created because Congress recognized that age requirements "may sometimes serve as a necessary proxy for neutral employment qualifications essential to the employer's business."[271] Given the purposes of the ADEA, however, the Court ruled that the BFOQ exception should be construed narrowly.[272]

In *Criswell,* the Supreme Court adopted the two-part test first articulated by the United States Court of Appeals for the Fifth Circuit in *Usery v. Tamiami Trail Tours.*[273] First, an employment classification based on age falls within the bona fide occupational qualification exception only where it serves as a proxy for a job qualification that is " 'reasonably necessary to the

264. *Id.*

265. *Id.* at 422 (quoting Reply Brief for Petitioner at 9 n.10).

266. *Id.*

267. *Id.* at 419. In so doing the Court rejected the test adopted by the United States Court of Appeals for the Seventh Circuit in Hodgson v. Greyhound Lines, Inc., 499 F.2d 859 (7th Cir. 1974), *cert. denied,* 419 U.S. 1122 (1975). At least in cases involving qualifications adopted for safety reasons, the *Hodgson* court had concluded that an employer need demonstrate only "that it has a reasonable basis in fact to believe that elimination of its maximum hiring age will increase the likelihood of risk of harm to its passengers." 499 F.2d at 863.

268. *Criswell,* 472 U.S. at 423.

269. *Id.* at 410.

270. *Id.*

271. *Id.*

272. *Id.* at 412.

273. 531 F.2d 224 (5th Cir. 1976).

essence of [the employer's] business.' "[274] A job qualification measured by age is not reasonably necessary if it is "peripheral to the central mission of the employer's business."[275]

Second, an age classification is "reasonably necessary only when the employer is compelled to rely on age."[276] An employer can make such a showing in either of two ways. The employer can establish that it " 'had reasonable cause to believe, that is, a factual basis for believing, that all or substantially all [persons over the age of qualification] would be unable to perform safely and efficiently the duties of the job involved.' "[277] Alternatively, the employer can prove that it is " 'impossible or highly impractical' to deal with older employees on an individualized basis."[278]

2. *The Four Part Test*

HEW regulations set out the elements of the normal operation exception under the ADA in a four-part test. The test is met if:

> (a) Age is used as a measure or approximation of one or more other characteristics; and
>
> (b) The other characteristic(s) must be measured or approximated in order for the normal operation of the program or activity to continue . . . ; and
>
> (c) The other characteristic(s) can be reasonably measured or approximated by the use of age; and
>
> (d) The other characteristic(s) are impractical to measure directly on an individual basis.[279]

"Normal operation" is defined as "the operation of a program or activity without significant changes that would impair its ability to meet its objectives."[280]

---

274. *Criswell,* 472 U.S. at 413 (quoting Usery v. Tamiami Trail Tours, 531 F.2d 224, 236 (5th Cir. 1976) (emphasis added)).

275. *Id.*

276. *Id.* at 414.

277. *Id.* (quoting Weeks v. Southern Bell Tel. & Tel. Co., 408 F.2d 228, 235 (5th Cir. 1969) (title VII case)).

278. *Id.* (quoting Weeks v. Southern Bell Tel. & Tel. Co., 408 F.2d 228, 235 (5th Cir. 1969)).

The issue before the Court in *Criswell* was the propriety of the jury instructions, not whether the standard had been correctly applied, which was a jury question. Nevertheless, the Court commented on the testimony of Western's experts, finding it outweighed by evidence that other reputable airlines do not require retirement of flight officers at age 60, that Western itself relied on individualized testing in similar circumstances, and that the FAA refused to establish a mandatory retirement age for flight officers. *Id.* at 423.

279. 45 C.F.R. § 90.14 (1987).

280. *Id.* § 90.13.

HEW modeled its interpretation of the normal operation exception on the ADEA BFOQ exception.[281] In all but one respect, the ADA normal operation standard mirrors that of the ADEA BFOQ exception, as interpreted by the Supreme Court in *Criswell.*

Under both the ADEA and the ADA regulations, age may be used as an employment or program criterion if it is used as a measure or approximation of some other characteristic. Under the normal operation exception, where age is used as a criterion itself, and not to represent another characteristic, its use will violate the ADA.[282]

Under both *Criswell* and the ADA regulations, the other characteristic must be "essential"—either to the employer's business or to the normal operation of the federally assisted program. While *Criswell* specifically used that term as applied to the ADEA's BFOQ, the ADA regulations imply the same meaning by finding the exception applicable only if necessary to the normal operation of the program; that is, the characteristic "*must* be measured or approximated" for the program to continue without impairing its ability to meet its objectives.[283]

The third prong of the ADA normal operation standard, as set forth in the HEW regulations, is implicit in the Court's reading of the ADEA in *Criswell:* age may be used as a proxy for another characteristic only where that characteristic can be reasonably measured by the use of age. There must be a "close relationship" between age and the characteristic being measured, but the regulations do not require that it be statistically valid.[284]

The only difference between the *Criswell* test and the ADA regulations lies in the standard for determining when individualized evaluation of qualifications is not required. The fourth prong of the ADA standard requires that the other characteristic be "impractical" to measure directly on an individ-

281. 44 Fed. Reg. 33,768, 33,781 (1979) (an analysis of comments on HEW final rule). The guidelines adopted by the Equal Employment Opportunity Commission for implementation of the ADEA state the test somewhat differently:

> (b) An employer asserting a BFOQ defense has the burden of proving that (1) the age limit is reasonably necessary to the essence of the business, and either (2) that all or substantially all individuals excluded from the job involved are in fact disqualified, or (3) that some of the individuals so excluded possess a disqualifying trait that cannot be ascertained except by reference to age. If the employer's objective in asserting a BFOQ is public safety, the employer must prove that the challenged practice does indeed effectuate that goal and that there is no acceptable alternative which would better advance it or equally advance it with less discriminatory impact.

29 C.F.R. § 1625.6(b) (1987).

282. 44 Fed. Reg. 33,768, 33,782 (1979). Where age is not measuring another characteristic, its use is wholly arbitrary.

283. *Id.* (emphasis added).

284. *Id.*

ual basis. *Criswell* allows the use of an age criterion only where it is "impossible or highly impractical" to insure by individual testing that an employee will have the necessary job qualifications.[285] The difference in the language of the fourth prong of the test appears to indicate a more relaxed standard under the ADA. The ADA regulations, however, do not explain why different language was chosen, although the choice was not inadvertent. Commentators suggested substitution of the word "impossible," but HEW did not adopt that more stringent standard.[286] While the difference in language might indicate that the costs or administrative inconvenience of individualized evaluations would be given greater weight under the ADA than under the ADEA, such an interpretation is not made explicit.[287]

3. *Cost-Benefit Considerations*

Another important issue, essentially left unresolved in the ADA regulations is the extent to which cost benefit considerations may justify targeting programs by use of age distinctions. All programs have limited funding, and administrators may need to limit the availability of the services provided. There are several different ways in which a program might respond to cost-benefit considerations. Program administrators might target services to those who are most likely to benefit, to those who are least costly to serve, to those most in need, or to those who will produce the greatest return on the program's investment by utilizing the education or training best or for the longest period of time. Any of these targeting approaches might use age as a criterion.

---

285. Western Air Lines, Inc. v. Criswell, 472 U.S. 400, 423 (1985). In addition to the circumstances already mentioned, the ADEA, as interpreted in *Criswell,* permits the use of an age qualification for employment where the employer can establish "a reasonable basis for believing that all or substantially all employees above [that] age lack the qualifications required for the position." Although the ADA regulations do not explicitly permit the use of an age cut-off under these circumstances, it is a reasonable interpretation of the statutory requirement and appears consistent with the regulations' interpretation of the ADA. Presumably, the emphasis here is on "all or substantially all." Thus, the employer or program must be able to establish that individualized determinations are unnecessary because there are so few over or under the designated age who would qualify.

286. *See* 44 Fed. Reg. 33,782 (1979).

287. The preamble to the regulations rejects a program's refusal to make changes in program operation "because those changes disturb administrative routine or are inconvenient." 44 Fed. Reg. 33,773 (1979). Section 90.14(d) of the proposed regulations permitted the use of age to measure another characteristic where that characteristic was "difficult, costly, or otherwise impractical to measure directly." When the final regulations were published, the references to cost and difficulty of measurement were deleted. 44 Fed. Reg. 33,782 (1979). Because it will always be more convenient and often less costly to use an age test, the mere fact of added cost or difficulty alone should not justify the use of an age distinction. Such a limitation seems essential to maintaining the integrity of the statute. *See infra* note 316 and accompanying text. At the same time, cost and difficulty should not be considered irrelevant. *See infra* note 322.

The ADA regulations neither condone nor prohibit the use of a cost-benefit analysis in the administration of federally assisted programs.[288] Instead, the regulations declare that any age test will have to meet the four-part normal operation standard and "cannot be disqualified or justified because it reflects a cost-benefit consideration."[289] The regulations also state that the four-part test will operate to screen out "discriminatory" cost-benefit considerations. Therefore, a key question involves the criteria applied to distinguish between discriminatory and permissible cost benefit considerations. The regulations avoid a complete answer to this question.

4. An Inadequate Test

Given the similarity in statutory language of the normal operation and BFOQ exceptions, as well as the legislative history linking the ADA and the ADEA, it was reasonable for HEW, the agency charged with writing and implementing the regulations, to pattern the standard for the normal operation exception after the test for a BFOQ.[290] At the same time, there were reasons to be wary of a wholesale adoption of the BFOQ standard.

---

288. The legislative history is generally inconclusive on this point. Only Representatives Quie and Pepper addressed the issue and they took opposing positions. It may be possible, however, to reconcile their positions. They seemed to be discussing two different cost-benefit rationales. Representative Quie referred to a program that cannot reach all students and, therefore, chooses those who, presumably, are most likely to benefit. *See supra* note 180. In contrast, Representative Pepper attacked a "cost-effectiveness" rationale that would exclude older individuals because they are more costly to serve. *See supra* note 215.

289. 44 Fed. Reg. 33,774 (1979).

290. The statement of purpose in the original ADA declared the intent of the Act to prohibit only "unreasonable" age discrimination and the 1975 Conference Report stated that the exceptions should be "modified by considerations of reasonableness." *See supra* note 176 and accompanying text. Nevertheless, the normal operation exception does not incorporate a reasonableness standard. As noted above, the statement of purpose did not modify the language of the exceptions. *See supra* note 215 and accompanying text. The language of the normal operation exception incorporates a more rigorous standard. Age distinctions are permitted only if they reasonably take age into account as a factor *necessary* to the normal operation of the program. 42 U.S.C. § 6103(b)(1)(A) (1982). In contrast, the exception for nonage factors which have a disproportionate adverse effect on the basis of age does permit the use of such a factor when it is *reasonable.* 42 U.S.C. § 6103(b)(1)(B). The language of the normal operation exception must prevail over that of the statement of purpose. A more consistent reading of the statement of purpose would acknowledge that it simply indicated an intent not to proscribe all age distinctions, regardless of their rationale.

Moreover, in 1978, the term "unreasonable" was deleted from the statement of purpose. While this amendment did not effect a substantive change, it did serve to defeat any argument that the normal operation exception has a reasonableness standard. Indeed, Representative Pepper considered that to be the effect of the amendment to the statement of purpose. *See supra* note 215.

Even though the legislative history did not mention the ADEA BFOQ exception itself as the basis for the normal operation exception, the legislative history and similar language show that Congress modeled the ADA after the ADEA. Thus, the statute itself contains a reasonable

In interpreting the ADA, HEW was faced with the task of formulating a rule to govern many factually different situations. The ADA involves not only employment opportunities, but programs that provide benefits of all degrees of importance to the individual, where denial of access to programs will have varying consequences. Denying an individual access to an athletic program does not have the same impact as denying an individual a job. While the essence of an employer's business is fairly simple to determine, the normal operation of a government program is a complex matter of competing concerns, priorities and interests.

HEW chose to modify the ADEA test by relaxing the fourth prong of the ADA test. A better approach would be to devise a flexible test that would take account of the context in which an age distinction is being used, while remaining fully consistent with the identified areas of congressional concern.

5. *A Flexible Standard*

a. *The Rationale for Judging Age Distinctions by a Higher Standard*

An age test may unfairly disadvantage a qualified individual who is not given an opportunity to prove that he or she is qualified. That alone should not invalidate age as a basis for classification, as most classifications are overbroad. The question for Congress, in judging age, was whether to treat it as just another admittedly imperfect classifying device or to subject it to a stricter test, such as that used for race or sex.[291]

---

necessity standard. Even if it does not, however, the HEW regulations are a reasonable interpretation of the statutory language.

Nonetheless, the ADA and ADEA are somewhat different. The ADA authorizes action which "*reasonably* takes into account age as a factor *necessary*" to a program's normal operation. 42 U.S.C. § 6103(b)(1) (emphasis added). The ADEA, in contrast, permits the use of age as an employment criterion when age is a "bona fide occupational qualification *reasonably necessary* to the normal operation of the particular business." 29 U.S.C. § 623(f)(1) (emphasis added). Arguably, this could justify different interpretations of the two provisions. Under the ADA, "reasonable" modifies the manner in which age is employed, but does not modify "necessary," arguably establishing a higher standard for the use of age. Use of an age criterion must be necessary to normal operation, not just reasonably necessary, as under the ADEA. There is no basis, however, for concluding that Congress intended to adopt a higher standard for the ADA. Both statutory provisions should be interpreted as adopting a test of reasonable necessity.

291. In 1976, the Supreme Court rejected a constitutional test of heightened scrutiny for classifications based upon age. Massachusetts v. Murgia, 427 U.S. 307 (1976), involved a state policy mandating retirement of police officers at age 50. The officer who was forced to retire challenged the rule, arguing that it violated the equal protection clause. *Id.* at 309-10. The Court rejected the argument that age classifications, like those involving race or national origin, should be upheld only if necessary to serve a compelling state interest—the strictest level of scrutiny under the equal protection clause. The Court stated:

> While the treatment of the aged in this Nation has not been wholly free of discrimination, such persons, unlike, say, those who have been discriminated against on the

There is little doubt that the use of age as a classifying device cannot be equated with the use of race or even with the use of sex.[292] One reason for close scrutiny of classifications based on race and sex is doubt about the accuracy of such classifications.[293] A judgment has been made that such classifications are rarely, if ever, related to ability. Moreover, there is a natural suspicion of classifications that disadvantage minorities and women because history demonstrates that these groups have often been the targets of discrimination, even by public officials. Therefore, they are in need of special protection from the majoritarian process.

---

basis of race or national origin, have not experienced a "history of purposeful unequal treatment" or been subjected to unique disabilities on the basis of stereotyped characteristics not truly indicative of their abilities. . . . [O]ld age does not define a "discrete and insular" group, . . . in need of "extraordinary protection from the majoritarian political process." Instead, it marks a stage that each of us will reach if we live out our normal span.

Id. at 313-14 (citation omitted).

The Court held that the lowest level of scrutiny—the rational basis test—should apply. *Id.* at 314. The Court presumed the validity of age classifications, requiring only proof that they were reasonable. *Id.* Applying that standard, it upheld the mandatory retirement policy.

That the State chooses not to determine fitness more precisely through individualized testing after age 50 is not to say that the objective of assuring physical fitness is not rationally furthered by a maximum-age limitation. It is only to say that with regard to the interest of all concerned, the State perhaps has not chosen the best means to accomplish this purpose. But where rationality is the test, a State "does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect.

Id. at 316 (footnote omitted).

The Court reaffirmed what it considered the inherent rationality of drawing distinctions based upon age in Vance v. Bradley, 440 U.S. 93 (1979). There, it characterized as "commonsense" the notion that "aging—almost by definition—inevitably wears us all down." *Id.* at 112. *Bradley* involved a mandatory retirement age of 60 for foreign service officers. *Id.* at 95.

292. There is a hierarchy of protected groups under both the Constitution and some civil rights statutes. For purposes of equal protection analysis, classifications based on race, national origin, and alienage are considered constitutionally suspect and subjected to the strictest scrutiny. They are upheld only when necessary to serve a compelling state interest. Attorney General of New York v. Soto-Lopez, 476 U.S. 898, 906 n.6 (1986). Gender classifications, as well as those based on illegitimacy, are judged by a middle level of scrutiny—whether they are substantially related to a significant state interest. Mississippi Univ. for Women v. Hogan, 458 U.S. 718, 724 (1982); Mills v. Habluetzel, 456 U.S. 91, 99 (1982). All other classifications, including those based on handicap or age, will be approved if found to have a rational basis. City of Cleburne v. Cleburne Living Center, 473 U.S. 432, 441-43 (1985).

These varying levels of scrutiny are, to some extent, also reflected in the civil rights statutes. Under the laws protecting equal employment opportunity—title VII of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000e to 2000e-17, and the ADEA—classifications based on sex, religion, national origin and age will be upheld if they are bona fide occupational qualifications, while race cannot be a BFOQ. Title VII prohibits the use of selection criteria based on generalizations about race without even inquiring into their accuracy.

293. Underwood, *Law and the Crystal Ball: Predicting Behavior with Statistical Inference and Individualized Judgment,* 88 YALE L.J. 1408, 1434-35 (1979).

Another reason for rejecting the legitimacy of classifications based on race or sex is that their use undermines our notions of individual autonomy.[294] The individual has no control over the immutable characteristic on which a decision is being based. The repeated use of such classifications has a cumulative effect, stigmatizing the members of the group and, ultimately, creating a discrete disadvantaged class.[295]

Age can easily be distinguished from these other group characteristics. First, it frequently bears a relationship to qualification or ability. Secondly, no age group has been subjected to the same history of discrimination as minorities and women. Indeed, older individuals are an organized and often powerful political group, and, therefore, less in need of judicial protection.[296]

At the same time, Congress saw some reason to question the accuracy and legitimacy of age distinctions. Although the depth of Congress' analysis can certainly be faulted, Congress did conclude that there was a history of discrimination based on age, with cumulative effects.[297] It noted a willingness among program administrators to accept stereotypes, without testing individual ability, and to see older individuals as less deserving of government benefits and services.[298] For these reasons, Congress enacted a statute prohibiting program beneficiaries from using age classifications unless reasonably necessary.

b. Distinguishing Among Age Distinctions: Factors to Consider

Despite this statutory stance, there is no reason to believe that Congress viewed all age distinctions as equally troublesome. Notably, Congress' findings were limited to the use of classifications based on advancing age.[299] Indeed, by exempting from statutory coverage all age distinctions "authorized by law," it indiscriminately approved a whole host of age classifications that have disabling effects.[300] Most of the disabling legislative uses of age approved under the exception, however, would seem to involve minimum, not maximum, age requirements.

In some respects, classifications based upon advancing age do bear some of the same attributes as those based on race and sex while classifications involving other age groups do not. Advancing age can be considered immu-

294. *Id.*
295. *Id.* at 1435-36.
296. The same, of course, cannot be said of the young.
297. *See supra* notes 217-30 and accompanying text.
298. *See supra* text accompanying notes 224-25.
299. *See supra* note 232-34 and accompanying text.
300. *See supra* note 235 and accompanying text.

table[301] because maximum age requirements have a certain finality which other age classifications do not. Once an individual has passed the age of qualification for a job or benefit, it is forever beyond reach. In contrast, the individual who is too young to qualify for participation in a program faces only a temporary barrier. That is not to say that a 17-year-old who is too young to vote is not deprived of an important right on the basis of an immutable characteristic. But the impact is mitigated because he or she will "outgrow" the disqualification. Thus, minimum age requirements are less threatening to our notions of individual autonomy.

Moreover, there is a stigma associated with advancing age. Our society views aging as a process of physical and mental decline. At some undesignated age, we reach our peak performance and it is all "downhill" from there. Thus, older persons are stereotyped as being less able and having less to contribute to society. Certainly, there are disabling stereotypes about youth but, again, they are only temporary disabilities and do not result in an undervaluing of the lives of younger individuals.

In contrast, as Dr. Flemming noted, "because older people are viewed as being less able to find employment or unable to work, they are not provided services or sought out as program participants."[302] As this remark demonstrates, distinctions based on advancing age have a cumulative effect on the elderly. Other age distinctions have a more random impact, sometimes disadvantaging one age group and sometimes another. There is no uniform minimum age requirement.

Moreover, age distinctions that treat children differently from adults are not based upon unfounded biases. Rather, they are based upon the widely accepted notion that children are not entitled to the same level of respect for their individual autonomy as adults.[303] In part, our willingness to treat children differently is based upon the belief that they lack a certain rationality and maturity necessary to assume adult responsibilities.

Thus, age is generally considered a valid indicator of physical and emo-

---

301. *See* Eglit, *Of Age and the Constitution,* 57 CHI.[-]KENT L. REV. 859, 907-09 (1981). Professor Eglit proposes a higher level of constitutional scrutiny for some age distinctions. *Id.* at 906.

302. *Legislation to Extend the Older Americans Act: Hearings Before the Subcomm. on Aging of the Senate Comm. on Labor and Public Welfare on S. 1425,* 94th Cong., 1st Sess. 390 (1975).

303. The notion of respect for individual autonomy rests upon an assumption of the existence of what has been called "moral agency"—the ability to form rational life choices. Teitlebaum, *supra* note 234, at 1000. In many areas of the law, however, it is assumed that children lack moral agency. Thus, they are required to attend school, and they may not freely marry or enter into contractual relationships. Most important, perhaps, they generally are required to submit to the authority of their parents.

tional maturity.[304] For that reason, in distinguishing between children and adults, we generally accept age as a measure of their needs and abilities. Our system of classifying children by age for education is a good example of our acceptance of these principles. When distinguishing among children or between children and adults, the value of age as an objective criterion would seem to outweigh the risk that an individual will be misclassified. For example, it would be unnecessarily burdensome to evaluate each applicant individually to determine whether he or she is sufficiently mature to drive a car.

Does this mean we should interpret the ADA to protect only older persons, much like the ADEA? The answer is no. Regardless of its wisdom, the ADA applies to all ages. That does not mean, however, that it must be applied in the same way in all situations.

Instead, the ADA's regulatory four-part test should be applied flexibly, in light of a number of considerations. Among the relevant factors are: the nature of the service or benefit provided by the program; the consequences to the individual of denial of the service or benefit, including whether it is temporary or permanent; and the consequences to the program of an error in selection of participants. Administrative efficiency and cost-benefit considerations may be given varying weight, depending upon the strength of each of these factors.

Consideration of these factors may result generally in a two-tiered standard—one for the elderly and one for other age groups. That is legitimate because the consequences of excluding an individual because of youth are often temporary and, therefore, less severe. Where a program designed to serve adults uses a maximum age limit to bar older individuals from fundamental opportunities in employment, health, or housing, the situation most resembles that which the ADEA, and, by extension, the ADA, was designed to prohibit. Under such circumstances, a strict application of the four-part test is appropriate.

By adjusting application of the four-part test on the basis of these articulated factors, the test becomes flexible enough to adjust to the many different contexts in which the statute applies.[305] Moreover, this approach does not

304. *See* 44 Fed. Reg. 33,768, 33,782 (1979).

305. Judicial interpretation of the ADEA provides precedent for such an approach. For example, in *Criswell* the Court recognized that more restrictive job qualifications may be applied when an inaccurate decision implicates safety, and stated that " '[t]he greater the safety factor, measured by the likelihood of harm and the probable severity of that harm in case of an accident, the more stringent may be the job qualifications designed to insure [safety].' " Western Air Lines, Inc. v. Criswell, 472 U.S. 400, 413 (1985) (quoting Usery v. Tamiami Trail Tours, 531 F.2d 224, 236 (5th Cir. 1976)). Thus, a court may be more concerned about the adequacy of individualized testing to evaluate the health of an airplane pilot than the health of one who sits behind a desk.

risk a general weakening of the four-part test that might permit use of the most pernicious age distinctions. There is also room for a stricter application of the test when an age distinction seriously disadvantages a younger person. For example, when a child is placed in an inadequate detention facility because of his or her age, the use of an age test is not simply a temporary impediment, but a present burden.

Congress could, and should, have done a better job of articulating the problem and tailoring a remedy. It would have been preferable for Congress to articulate a flexible standard. If the ADA is to have any meaning, however, the agencies and courts should take up the challenge to devise a standard consistent with congressional intent.[306]

c. How a Flexible Standard Would Work

It generally is agreed that the ADA was enacted primarily to eliminate the unnecessary use of age distinctions. Each prong of the normal operation exception is designed to determine whether the use of age in a given program is reasonably necessary, and therefore, each prong should be applied flexibly in light of the factors described above.

The first and second prongs permit the use of age only when necessary to evaluate a characteristic that must be measured in order for a program's normal operation to continue. What is necessary for a program's normal operation is generally a question of fact that is determined by examining the program's experience, in addition to the experience of other, similar programs.

The major issue in applying the second prong of the exception is assessing whether cost-benefit considerations justify targeting program benefits to a particular age group. Where resources are limited, targeting program benefits to a limited group of beneficiaries may be a legitimate and necessary program objective. A cost-benefit analysis may be an appropriate means of deciding how to best target limited resources. However, when a cost-benefit analysis uses age distinctions to exclude some potential beneficiaries, it must be examined critically.

As noted above, not all cost-benefit analyses emphasize the same factors. Whether a particular cost-benefit calculation is permissible depends upon the nature of the program to which it applies. For each program, targeting should be accomplished in a manner consistent with other recognized objectives of the program. For example, because the beneficiaries of a program of

306. Unfortunately, this effort may be condemned as administrative and judicial overreaching instead of being seen for what it is—the inevitable result of Congress' failure to perform its proper role.

immunization against contagious diseases generally are defined by need, the program could target its services to those most susceptible to a particular disease, even if that targeting is done on the basis of age.[307]

When a statute defines a program's objectives, program administrators will not find it difficult to determine whether targeting is consistent with the statutory objectives. Objectives, however, often will not be well-defined. In those instances, who should decide whether it is appropriate to target services to those who will benefit the most, to those most in need, or on some other basis; or, whether the program should simply provide services on a first-come, first-served basis? These are policy decisions involving value judgments that are unsuitable for judicial determination.

This factor tests the program's use of the characteristic that age measures, not the use of age itself. For that reason, it may be appropriate to afford program administrators wide discretion in choosing a method of targeting. The purpose of the ADA is to prevent age discrimination, not to dictate to program administrators what their objectives should be.[308]

At the same time, there is more reason to be wary of a cost benefit rationale that serves to disadvantage those of advancing age. Congress clearly was concerned with the willingness of program administrators to undervalue the

307. The preamble to the HEW regulations approves the use of age to define the beneficiaries of an immunization program. It concludes that age is a reasonable measure of susceptibility and that it is impractical to measure susceptibility on an individual basis. 44 Fed. Reg. 33,774 (1979).

308. Of course, one way of targeting by age is for a program to define its objectives as serving the needs of a particular age group if that group does, indeed, have distinct needs or abilities. The preamble to the ADA regulations issued by the HHS uses the example of a Head Start program which only accepts children over the age of three. 47 Fed. Reg. 57,850, 57,856-57 (1982). Because the program is highly structured and stresses group activities, it can meet its objectives only if the children it accepts have reached a certain level of development and capacity for self-discipline. *Id.* at 57,857. The preamble concludes that including younger children who might need more assistance in feeding, changing diapers, and clothes, would "impair the [program's] ability to meet its objectives." *Id.*

Similarly, the preamble to the HEW regulations approves the use of a maximum age limit on membership in a federally assisted youth organization whose purpose it is to provide training, education, and character development for youth. 44 Fed. Reg. 33,773 (1979). The preamble states that the program is designed to provide training, education, and character building experiences preparing for the assumption of adult responsibility, that age is highly related to the need for the services, and that the need cannot be measured on an individualized basis. *Id.*

The same rationale would justify any school in grouping children in grades by age, reflecting differences in physical, mental or emotional development. It follows that when an athletic or enriched science program cannot be offered to all students, school officials may target it to a particular grade.

Programs that distinguish on the basis of age among children or youths would seem to be of least concern. The impact of such distinctions is random. Indeed, Representative's Quie's remarks indicated a willingness to accept such distinctions. *See supra* note 180.

lives of older persons.[309] Where a program designed to provide benefits to adults seeks to target its limited resources in a way that excludes individuals over a certain age, it should be viewed with suspicion. For example, defining a program objective as targeting those who can derive the most benefit may simply be another way of excluding older individuals because they are perceived to have diminished social value.[310] Under these circumstances, a court should give closer attention to the legitimacy and necessity of the means of targeting resources.

Indeed, at least one cost-benefit rationale—that based upon the longevity of the program beneficiary—must be rejected outright. The preamble to the HEW regulations discusses the example of a medical school that refuses to admit applicants over the age of thirty-five because it wants to reserve its limited spaces for those who, upon graduation, will practice medicine for as long as possible.[311] The preamble acknowledges that age may be a reasonable measure of length of practice and that it is impractical to predict length of practice on an individualized basis.[312] The preamble concludes, however, that the practice violates the statute because "achieving longevity of practice for its graduates cannot be considered a program objective for a medical school within the meaning of the Act."[313] Thus, at least in this and similar instances, a program may not use "broad notions of efficiency or cost-benefit analysis" to justify exclusion on the basis of age.[314]

While the medical school example purports to analyze this use of age under the four-part test, in actuality it fails to do so. The regulations reach the correct conclusion, but it would have been preferable to recognize that there is another element to the second prong of the normal operation exception: the program objective identified by the recipient of federal funds as justifying the use of age must not be one that the ADA has made impermissible.[315] Maximizing the longevity of program participants is just such an

309. *See supra* text accompanying notes 218-19.

310. It is likely that this concern prompted the HEW regulations to reject targeting resources by age under the Adult Education Act. The purpose of the adult education program is to "enable all adults to continue their education . . . and . . . enable them to become more employable, productive, and responsible citizens." 44 Fed. Reg. 33,774 (1979). The regulations declare that employability, productivity, and responsibility need not be measured under this program because its objective is not to "maximize the degree of improvement," but to improve these characteristics in the individual. *Id.*

311. 44 Fed. Reg. 33,773 (1979).

312. *Id.* at 33,774.

313. *Id.*

314. *Id.*

315. It is disingenuous simply to say that longevity of practice is not a legitimate objective of a medical school. If it is not legitimate for a medical school, it is difficult to imagine a

impermissible objective.[316] Thus, the second prong inquires into the purpose for which age is employed. If the purpose is illegitimate, the inquiry need proceed no further.

The third prong of the normal operation exception requires a close relationship between the use of age and the characteristic measured. The HEW regulations do not explain the standard for judging whether the relationship is close, except insofar as they reject the need to show a statistically significant relationship.[317]

Borrowing from another section of the HEW regulations, it is appropriate to require that the relationship be "direct and substantial." HEW has established that standard to test the connection between "reasonable factors other than age" that have a disproportionate impact on a particular age group and the normal operation of a program.[318] The standard for judging the use of explicit age classifications should be at least as rigorous as the test for judging the use of nonage factors that have a disproportionate impact on an age group.

---

program in which it would be a legitimate objective. It is more accurate to simply recognize that longevity of practice is an objective inconsistent with the purposes of the statute.

316. The rejection of a longevity rationale is consistent with the way some courts have interpreted the ADEA. In Smallwood v. United Air Lines, Inc., 661 F.2d 303 (4th Cir. 1981), *cert. denied,* 456 U.S. 1007 (1982), the United States Court of Appeals for the Fourth Circuit reviewed the defendant airline's rule denying pilot positions to applicants who were over the age of 35. United sought to justify its maximum age rule as a safety measure and introduced evidence showing a higher incidence of medical problems in older pilots. *Id.* at 306-07. The court of appeals found, however, that the airline had failed to demonstrate a relationship between the evidence and the rule establishing a maximum hiring age. *Id.* at 309. The court suggested that United's real motive was cost-related. Given the substantial costs of training, the airline wanted to maximize a pilot's period of peak productivity. *Id.* at 307. Such cost-benefit considerations, the court held, cannot be the basis for a bona fide occupational qualification because "precisely those considerations were among the targets of the Act." *Id.* The United States Court of Appeals for the Ninth Circuit, citing *Smallwood,* rejected a similar maximum hiring age policy for helicopter pilots in EEOC v. County of Los Angeles, 706 F.2d 1039, 1042 (9th Cir. 1983), *cert. denied,* 464 U.S. 1073 (1984). The United States Court of Appeals for the Eighth Circuit expressed approval of this interpretation of the ADEA. *See* Leftwich v. Harris-Stowe State College, 702 F.2d 686, 691-92 (8th Cir. 1983).

Similarly, it is questionable whether targeting to the least costly to employ can be a legitimate objective. The EEOC's ADEA guidelines note that the ADEA prohibits "[a] differentiation based on the average cost of employing older employees as a group." 29 C.F.R. § 1625.7(f) (1987); *see also* 29 C.F.R. § 860.103(h) (1987) (Department of Labor guidelines). Some courts have concluded that although reducing costs is a legitimate business goal, it may not be accomplished in a manner that singles out older workers. *See, e.g.,* EEOC v. City of Altoona, 723 F.2d 4, 7 (3d Cir. 1983), *cert. denied,* 467 U.S. 1204 (1984); *Leftwich,* 702 F.2d at, 691-92; Geller v. Markham, 635 F.2d 1027, 1034 (2d Cir. 1980), *cert. denied,* 451 U.S. 945 (1981); Laugesen v. Anaconda Co., 510 F.2d 307, 316-17 (6th Cir. 1975); *see also supra* note 215 (remarks of Rep. Pepper).

317. 44 Fed. Reg. 33,768, 33,782 (1979).

318. 45 C.F.R. § 90.15 (1987).

A program should be required to support its use of age with factual information.[319] A relationship between age and the characteristic measured should not be presumed. Various kinds of proof may be offered to support a direct relationship between age and the necessary characteristic. In ascending order of persuasiveness, the proof may include: testimony based upon the experience of program administrators; expert opinion; empirical studies of the general effects of aging and of the relationship of age to various physical and mental capacities; and, finally, professionally developed validity studies of the use of age in a given program.

Depending upon the factors cited above—nature of the service, consequences to the individual and to the program—courts and enforcement agencies should vary the evidentiary showing necessary to support the use of an age distinction. When the consequence to the excluded individual is the loss of an important benefit, it may be appropriate to require at least some empirical evidence of the relationship between age and the crucial characteristic.[320]

The more important question arises in deciding where the age line should be drawn. Merely showing a relationship between age and a given characteristic does not justify the use of any particular age cut-off. For example, even if age is related to emotional maturity, it would not be reasonable to set age thirty as the minimum age for driving motor vehicles.

Is it reasonable to use an age cut-off that screens out fifty percent of those who are qualified, or thirty percent, or five percent? No certain answer to this question exists in the ADA or in logic. A program should be required to justify the chosen cut-off age by evidence that it will not exclude a substantial number of qualified individuals. What is considered substantial may vary with the importance of the benefit or service and the program's interest

319. Although the ADEA cases do not explicitly discuss the type of proof necessary to establish a relationship between age and the characteristic that it is measuring, the statute seems to require a factual basis for linking the two factors. At least where an age criterion is permitted because "all or substantially all" persons over or under that age are unqualified, the employer must have "reasonable cause to believe, that is, a factual basis" for, its conclusion. *See supra* note 281.

320. The ADA does not really seem to question that there is a relationship between age and the characteristics upon which age distinctions are based. No evidence exists to show that Congress doubted the relationship of age and physical, mental, and emotional maturity in children. Nor did anyone question the relationship between advancing age and poorer health or physical decline. Rather than question these generalizations, the ADA seeks to prevent the unfair application of a generalization to disadvantage an individual for whom the generalization may not be true. Thus, the fourth prong of the test—requiring an individualized determination—may be the most crucial. Certainly, when the necessary characteristic can be measured individually, age need not be used as a proxy. There will, however, be instances where individualization will be impractical. In those cases, the relationship between age and the necessary characteristic takes on added importance.

in reducing the chance of selecting unqualified individuals.[321] Here also, the type of evidence required to demonstrate the impact of an age cut-off would vary with the nature and consequences of the program.

The fourth prong of the normal operation exception is the heart of the ADA. It is designed to prevent the use of age as a measure of qualification when other means of making that determination are available. The HEW regulations require individual evaluation of program beneficiaries unless such an evaluation is "impractical." That standard should be applied flexibly. Where the consequence to the individual is the loss of an important benefit, individualization should be required if it is feasible and if it will not undermine the normal operation of the program.

When the cost of individualized determinations becomes so great that it would impair the operation of the program, it should not be required.[322] Thus, the test would not require individualized determinations of the health of pilots over sixty if, to be reliable, such determinations would have to be made before every flight. Similarly, a special education program may have financial resources to hire only enough teachers to teach children in three grades. Although students might be selected individually from all grades, the majority of students would not have teachers. In that case, individualization would impair the program's objectives.[323]

At the same time, other situations may exist where it may be feasible to individualize, but only at great cost and inconvenience—and with little anticipated benefit.[324] For example, it would be unnecessarily costly and bur-

321. In determining the constitutionality of gender classifications, the Supreme Court has required a showing of a substantial relationship between gender and the characteristic for which it is used as a proxy. The Court has rejected, as an insubstantial "fit," mandatory dependency tests for men and not for women "even though it recognized that husbands are still far less likely to be dependent on their wives than vice versa." Craig v. Boren, 429 U.S. 190, 202 n.13 (1976) (referring to Frontiero v. Richardson, 411 U.S. 677 (1973) and Weinberger v. Weisenfeld, 420 U.S. 636 (1975)).

322. Although HEW seems to have rejected inconvenience and cost alone as justifications for the use of an age distinction, the regulations do not actually preclude all consideration of such factors. *See supra* note 287. At the very least, if the cost or administrative burden of the individualized determinations is so great as to "impair [the] ability [of a program] to meet its objectives," individualization should not be required. 45 C.F.R. § 90.13 (1987)

323. Indeed, Rep. Quie's remarks during debate on the ADA suggests this situation. *See supra* note 180.

324. The example of the Head Start program found in the preamble to the HHS regulations seems to suggest that individualization may not be required even though it is feasible. *See supra* note 307. The preamble would allow the use of age as a proxy for level of development and capacity for self-discipline even though it would seem to be possible to evaluate these characteristics on an individual basis. 47 Fed. Reg. 57,850, 57,857 (1982).

Indeed, a review of the examples in the preamble to the HEW regulations suggests that the agency may have been applying its standard differently to age distinctions that disadvantage

densome to replace a minimum age for driving by an individualized test of maturity. In that instance, a minimum age requirement represents a temporary disability that can be "outgrown." Therefore, the advantages of using a uniform objective measure of qualification far outweigh the benefits of individualizing. At the same time, when individualization is not required it would be prudent to require greater proof of the relationship between age and the characteristic to be measured.

III. The Use of Age as a Criterion for Rationing Medical Care

Like its model—title VI—the ADA extends its protections only to individuals who participate or seek to participate in "a program or activity receiving federal financial assistance." Such a program or activity may not exclude, deny benefits, or discriminate against any person on the basis of age.

Thus, in applying the ADA to the rationing of medical care, several questions must be addressed: (1) Does the health care provider operate a program or activity receiving federal financial assistance? (2) Does the manner in which medical treatment is provided or denied by that program or activity constitute exclusion, denial of benefits, or discrimination within the meaning of the statute? In other words, are medical treatment decisions subject to scrutiny under the ADA? (3) Does the consideration of age violate the prohibition of the statute, or is it authorized by a statutory exception? In order to provide a framework for discussion of these issues, this section of the article will focus on the rationing of heart transplants.

As noted above, institutions that perform heart transplants have considered the age of prospective patients in evaluating their suitability as heart transplant recipients. Typically, age has been employed as a criterion of absolute exclusion.[325] That is, individuals over the age of fifty-five have been excluded from consideration.

---

older individuals than to those involving children and youth. Nevertheless, if the agency is putting a gloss on the regulations, it should be made explicit.

325. *See supra* notes 122-23 and accompanying text. There have been exceptions to this general rule. *See* HCFA Ruling, *supra* note 72 at 13,641. If there is a consistent basis for making exceptions, then the rule is not really a rule of absolute exclusion. On the other hand, if the exceptions are simply made on an ad hoc basis, they do not alter the exclusionary nature of the rule as it applies to most patients. Primary physicians and cardiologists use the articulated criteria to advise patients about the availability of a heart transplant as a possible treatment option and as a basis for referring patients to a transplant program. If articulated criteria include an age cut-off, many prospective patients will never even seek a transplant.

Although the Medicare ruling does not read like a rule of absolute exclusion, it warns that selection of a patient over 50 "must be done with particular care." *Id.* Since Medicare approval depends upon adherence to the patient selection criteria and achieving a high rate of survival, it is likely that a hospital would apply this criteron narrowly. HHS has stated clearly

Hospitals generally have a two-tiered selection process. Patients who are referred by their own physicians are initially reviewed on the basis of their medical records. If an individual passes this screening, he or she is given a comprehensive individual evaluation, which may include taking a medical history, a clinical examination, laboratory studies (including respiratory, liver, and kidney function studies), a cardiac catheterization, a psychosocial profile, a nutritional assessment, and an immunologic workup.[326] Selections may be made by a medical review board, which consists of medical doctors (including a cardiologist and cardiac surgeon), immunologists, hospital administrators and social workers,[327] or by a more informal group of physicians and other individuals. Age generally has been applied at the first level to exclude the patient from an individual evaluation.[328]

After an individual is determined to be a suitable candidate for a heart transplant, the individual's name is placed on a hospital's own waiting list or a regional registry. When an organ procurement agency, which may be a hospital or independent organization, obtains a donor heart, it attempts to find the best recipient, largely from the names on a waiting list or registry.[329] Priority generally has been given to those who have the best "match"[330] and the most urgent need.[331] Thus, an individual whose name is not placed on a waiting list or in a registry will have little chance of securing a heart transplant.

---

that "an individual who fails to meet all the criteria would not be a suitable transplant candidate. *Id.* at 13,625.

326. *See, e.g.*, Frazier, Cooley, Okereke, Van Buren & Kahan, *Cardiac Transplantation at the Texas Heart Institute: Recent Experience*, 81 TEXAS MEDICINE, December 1985, at 48 [hereinafter Frazier]; Painvin, Frazier, Chandler, Cooley & Reece, *Cardiac Transplantation: Indications, Procurement, Operation and Management*, 14 HEART AND LUNG 484 (1985) [hereinafter Painvin].

327. Christopherson, *Heart Transplants*, in 12 "TO MEND THE HEART": ETHICS & HIGH TECHNOLOGY, THE HASTINGS CENTER REPORT 18, 19 (1982). Frazier, *supra* note 326, at 48.

328. *See supra* note 325 and accompanying text.

329. TASK FORCE REPORT, *supra* note 59, at 65-66.

330. Heart transplant patients and donors are tested for incompatability of blood type. Matching also is based on the size of the organ and the donor's geographic location. At present, hearts can be maintained outside the body for only a matter of hours. This precludes doing most tissue matching. It also places limitations on the distance a donor heart can be transported. *Id.* at 66-67.

331. *Id.* at 66. The Task Force on Organ Procurement and Transplantation recommended that allocation of organs be based on criteria that consider need and probability of success. *Id.* at 89. It noted that "[m]any believe that the fairest procedure is to use broad medical criteria to establish the waiting list and then to use narrower medical criteria to determine who actually receives an available organ." *Id.* at 87.

A. A Heart Transplant Program Is a Program or Activity Receiving Federal Financial Assistance

Section 6102 of the ADA prohibits age discrimination in any "program or activity receiving [f]ederal financial assistance."[332] The Civil Rights Restoration Act of 1987[333] amended, and thereby broadened, the scope of the ADA by defining the term "program or activity" to include "*all* of the operations of . . . *an* . . . *organization which is principally engaged in the business of providing* . . . *health care* . . . any part *of which is extended Federal financial assistance.*"[334] Thus, the Civil Rights Restoration Act effectively overruled part of *Grove City College v. Bell,*[335] where the Supreme Court narrowly interpreted the term "program or activity" in title IX of the Education Amendments of 1972.[336] In *Grove City,* the Court held that because the only program or activity receiving federal financial assistance was the college's financial aid program, only that program—not the entire college—

---

332. 42 U.S.C. § 6102 (1982).

333. Pub. L. No. 100-259, 1988 U.S. CODE CONG. & ADMIN. NEWS (100 Stat.) 28 (to be codified in scattered sections of U.S.C.). The Civil Rights Restoration Act was enacted on March 22, 1988 after Congress overrode a veto by President Ronald Reagan. *See* Dewar, *Congress Overrides Civil Rights Law Veto,* The Wash. Post, March 23, 1988, at A-1, col. 5. In addition to amending the ADA, Pub. L. No. 100-259, § 5, the Act amends title IX of the Education Amendments of 1972, *id.* § 3, § 504 of the Rehabilitation Act of 1973, *id.* § 4, and title VI of the Civil Rights Act of 1964, *id.* § 6.

334. Pub. L. No. 100-259, § 5 ((to be codified at 42 U.S.C. § 6107(4)(C)(i)(II)). Curiously, Congress did not choose to amend § 6104(b) of the ADA, which, in addressing fund termination, specifies:

> Any such [fund] termination or refusal shall be limited in its effect to the *particular* program or activity, or *part* of such program or activity, with respect to which such finding [of age discrimination] has been made. No such termination or refusal shall be based in whole or in part on any finding with respect to any program or activity which does not receive Federal financial assistance.

42 U.S.C. § 6104(b) (1982) (emphasis added).

Representative Quie, the author of § 6104(b), explained that it was adopted to reject the so-called "infection theory" which, he stated, HEW had used under title VI and title IX to reach alleged discrimination in programs not receiving federal financial assistance and to use that as a reason for terminating assistance to other programs. Representative Quie explained that HEW's application of the "infection theory" had led Congress to amend title IX to exempt school supported Boy and Girl Scout programs from coverage. According to Representative Quie, this provision was needed to limit the scope of HEW's inquiry to the programs actually supported by federal assistance. 121 CONG. REC. 37299 (1975). Given the broader definition of program or activity contained in the Civil Rights Restoration Act of 1987, § 6104(b) would seem to have little effect. Moreover, even prior to passage of that act, the United States Court of Appeals for the Fifth Circuit, in United States v. Baylor Univ. Medical Center, 736 F.2d 1039 (5th Cir. 1984) *cert. denied,* 469 U.S. 1184 (1985), held that all inpatient and emergency room operations of a hospital receiving Medicare and Medicaid were part of the program or activity supported by the assistance. 736 F.2d at 1042.

335. 465 U.S. 555 (1984).

336. *Id.* at 574-75.

was subject to the provisions of title IX.[337]

By expanding the definition of "program or activity" in the ADA[338] to encompass *all* of the operations of a health care organization, *any part* of which receives federal financial assistance, the Civil Rights Restoration Act renders a hospital's heart transplant program subject to the provisions of the ADA if any part of the hospital receives federal financial assistance.

There seems to be little doubt that a hospital that participates in Medicare[339] or receives reimbursement under a state Medicaid program[340] receives federal financial assistance. In *United States v. Baylor University Medical Center,*[341] the United States Court of Appeals for the Fifth Circuit found that conclusion compelled by the legislative histories of title VI of the Civil Rights Act of 1964 and the 1965 statute creating the health programs. *Baylor* involved the applicability of section 504 of the Rehabilitation Act of 1973 to hospital services.

At the time title VI was passed there were federal programs to reimburse health care providers for medical care of the poor.[342] The court of appeals held that discrimination by hospitals and other medical facilities that received federal funding through these programs was one of the specific targets of title VI.[343] Moreover, during debate on the Medicare and Medicaid legislation, several senators stated that the prohibitions of title VI would apply to recipients of Medicare and Medicaid payments.[344] Although this issue was

337. *Id.*

338. The Civil Rights Restoration Act similarly expanded the term "program or activity" as used in title IX of the Education Amendments of 1972, § 504 of the Rehabilitation Act of 1973, and title VI of the Civil Rights Act of 1964. Pub. L. No. 100-259, §§ 3, 4, 6, 1988 U.S. CODE CONG. & ADMIN. NEWS (100 Stat) 28-30.

339. Under Medicare Part A, the government pays the hospital for certain in-hospital treatment for covered aged and disabled persons. The program is financed entirely by payroll tax deductions, 42 U.S.C. § 1395 (1982), and federal payments may be made only to hospitals which meet certain conditions of participation established by the Secretary of Health and Human Services. *Id.* § 1395(d)(2). *See* United States v. Baylor Univ. Medical Center, 736 F.2d 1039, 1044 (5th Cir. 1984), *cert. denied,* 469 U.S. 1189 (1985).

340. The Medicaid program provides state governments with federal funds that the state, after establishing a federally approved plan, uses to pay for medical aid for the poor and disadvantaged. 42 U.S.C. § 1396; *see Baylor,* 736 F.2d at 1044.

341. 736 F.2d 1039 (1984).

342. *Id.* at 1044. Among these programs was the Kerr-Mills program of health care for the poor, 42 U.S.C. §§ 301-306 (1982). *See* 110 CONG. REC. 13,132 (1964). The Medicaid legislation passed in 1965 was an expansion of that program.

343. *Baylor,* 736 F.2d at 1044. For example, Representatives Lindsay, McCulloch, Cahill, Shriver, MacGregor, Mathias, and Bromwell expressed the view that title VI would prohibit racial discrimination in "vendor payments for medical care of public assistance recipients. Hospitals, nursing homes, and clinics in all parts of the country participate in these programs." 110 CONG. REC. 1661 (1964).

344. *See, e.g.,* 111 CONG. REC. 15,803 (1965) (remarks of Sen. Ribicoff) (in order to receive

not extensively debated, the court noted that no member of Congress expressed a contrary view.[345]

The similarity of structure, language, and purpose of the several statutes prohibiting discrimination in federally funded programs—title VI, title IX, and section 504—requires that they be interpreted consistently; the legislative history and judicial construction of an earlier statute is highly relevant to interpretation of a later-enacted law.[346] Thus, in *Baylor,* the court reasoned that because section 504 uses language *identical* to that of title VI to describe the statute's coverage, the legislative history of title VI is relevant in interpreting section 504.[347] The same principle applies when interpreting the coverage of the ADA, which was also patterned after title VI and which uses the same language.

Grove City laid to rest any argument that Medicare and Medicaid are financial assistance only to the individual beneficiary and not to the recipient hospital.[348] In *Grove City,* the Supreme Court held that Basic Educational Opportunity Grants—federal grants extended to college students for college expenses—are federal financial assistance within the meaning of title IX of the Education Amendments of 1972, even when the aid is given directly to the student and not to the college.[349] An even stronger argument can be made that Medicare and Medicaid payments, which are made directly to health care providers, are federal financial assistance to the providers.

The Court, in *Grove City,* also rejected the argument that the education grants were analogous to food stamps, Social Security benefits, welfare payments, and other forms of general-purpose governmental assistance to low-

federal payments, hospitals would have "to abide by Title VI"); 111 CONG. REC. 15,813 (1965) (remarks of Sen. Hart); *id.* (remarks of Sen. Pastore). The court noted the particular importance of the remarks of Senators Ribicoff and Pastore who were closely involved in passage of both title VI and the health legislation. *Baylor,* 736 F.2d at 1045 n.14.

345. *Baylor,* 736 F.2d at 1045.

346. *See, e.g.,* Grove City College v. Bell, 465 U.S. 555, 566 (1984); Cannon v. University of Chicago, 441 U.S. 677, 683-85 (1979).

347. *Baylor,* 736 F.2d at 1043, 1045, 1047.

348. The Civil Rights Restoration Act of 1987 did not alter the section of the *Grove City* opinion that concluded that federal financial assistance directly awarded to individual beneficiaries is "federal financial assistance" within the meaning of title IX.

349. 465 U.S. at 569-70. The Court rejected any distinction between direct aid to institutions and indirect aid received through individual student beneficiaries. *Id.* at 564. The Court noted that the "economic effect of direct and indirect assistance often is indistinguishable . . . and the [student aid] program was structured to ensure that it effectively supplemented the College's own financial aid program." *Id.* at 565. Students receive grants to pay for the education they receive at a particular college or university. Their eligibility is conditioned on continued enrollment. The amount of the grant is based on the cost of attendance, and students must sign affidavits stating that their awards will be used solely for expenses related to attendance. *Id.* at 565 n.13.

income families, which do not invoke statutory coverage.[350] In support of its conclusion, the Court noted that, unlike general assistance, an individual's eligibility for educational assistance is tied to attendance at an educational institution, and that the assistance is designed to aid the educational institution.[351] Furthermore, educational institutions may withdraw from federal student assistance programs.[352]

Similarly, as the Fifth Circuit held in *Baylor,* Medicare and Medicaid payments to hospitals for the care of individual beneficiaries are federal financial assistance. Medicare and Medicaid payments are dependent upon the beneficiary receiving care from a participating health care provider. Providers may withdraw from the program. The Medicare and Medicaid programs provide some assistance to hospitals in meeting their statutory and common law obligations to provide care to the indigent.[353] The fact that Medicare and Medicaid assistance is provided to hospitals for the care of individual beneficiaries does not distinguish it from a whole host of federal programs that provide funding so that individuals may provide services to the ultimate beneficiaries of federally assisted programs.[354]

Because hospitals that participate in Medicare and Medicaid are recipients of federal financial assistance, all of the operations of such hospitals are subject to compliance with the ADA. This includes heart transplant programs, even if the transplant programs themselves do not participate in Medicare and Medicaid[355] and are completely segregated from other hospital services

350. *Id.* at 565 n.13.

351. *Id.*

352. *Id.*

353. A private hospital has no general duty to provide care to those who cannot pay. *See, e.g.,* Agnew v. Parks, 172 Cal. App. 2d 756, 343 P.2d 118 (1959). Where, however, a hospital has a custom of providing emergency care it may be legally obligated to provide emergency care on demand to patients who rely on this custom. *See, e.g.,* Hiser v. Randolph, 126 Ariz. 608, 611, 617 P.2d 774, 777 (1980), *overruled on other grounds sub nom.* Thompson v. Sun City Community Hosp., Inc., 141 Ariz. 597, 688 P.2d 605 (1984). In addition, once a hospital admits a patient, it may not unreasonably discharge the patient and will be liable for any harm suffered by the patient as a result of the premature discharge. *See, e.g.,* Le Juene Rd. Hosp., Inc. v. Watson, 171 So. 2d 202, 204 (Fla. Dist. Ct. App. 1965). Hospitals that receive federal financial assistance for construction under the Hill-Burton Act have an obligation to provide some care to those who cannot pay. 42 U.S.C. § 291c(e) (1982). Public hospitals may have specific statutory and constitutional obligations to indigent patients.

354. During the debate on title VI, Congress was provided lists of programs that would be covered. The list included expenditures for school districts, student loans, hospital construction, maternal and child health, and low income housing assistance. 110 CONG. REC. 13,380-82 (1964).

355. This is unlikely because Medicare now covers heart transplants and 24 states pay for heart transplants under their Medicaid programs. *See supra* notes 59, 72, and accompanying text.

that do participate in Medicare and Medicaid.[356]

356. One further issue arises with respect to Medicare and Medicaid. Like title VI, the ADA specifically exempts from coverage a federal "contract of insurance or guaranty." Section 6103 provides that:

> [t]he head of each Federal department or agency which extends Federal financial assistance to any program or activity by way of grant, entitlement, loan, or contract other than a contract of insurance or guaranty, shall transmit to the Secretary [of HEW, now HHS], and publish in the Federal Register, proposed regulations to carry out the provisions of section 6102 . . . .

42 U.S.C. § 6103 (1982). The language of title VI is similar. *See* 42 U.S.C. § 2000d-1 (1982).

In *Baylor,* the hospital argued that Medicare and Medicaid were insurance programs and therefore exempt from coverage. The court found, however, that Medicare is not the kind of insurance that Congress intended to exempt from the coverage of title VI. *Baylor,* 736 F.2d at 1048-49. The legislative history of title VI, *see* 110 CONG. REC. 2500 (1964) (comments of Rep. Celler); *id.* at 6545 (comments of Sen. Humphrey); *id.* at 6566 (analysis of House bill); *id.* at 9090 (comments of Sen. Gore); *id.* at 13,378 (comments of Sen. Humphrey), indicates that Congress intended to prevent title VI from reaching "individually owned homes financed with federally guaranteed mortgages, or individual bank accounts in a bank with federally guaranteed deposits," because it did not "want Title VI to effect a nationwide Fair Housing Act." *Baylor,* 736 F.2d at 1048.

In contrast to this kind of voluntary, individually financed, agreement, Medicare is a mandatory program, financed by mandatory payroll taxes. Like Social Security, which is financed in the same way, Medicare benefits are noncontractual in nature and do not create property rights in the beneficiary. In so holding in Flemming v. Nestor, 363 U.S. 603 (1960), the Supreme Court noted:

> The Social Security system may be accurately described as a form of social insurance, enacted pursuant to Congress' power to "spend money in aid of the general welfare," . . . whereby persons gainfully employed, and those who employ them, are taxed to permit the payment of benefits to the retired and disabled, and their dependents. Plainly the expectation is that many members of the present productive work force will in turn become beneficiaries rather than supporters of the program. But each worker's benefits, though flowing from the contributions he made to the national economy while actively employed, are not dependent on the degree to which he was called upon to support the system by taxation. It is apparent that the noncontractual interest of an employee covered by the Act cannot be soundly analogized to that of the holder of an annuity, whose right to benefits is bottomed on his contractual premium payments.

Id. at 609-10.

Although the legislators used the term "insurance" when referring to Medicare, it was meant in the sense of "social insurance." Indeed, the bill was variously described as "social insurance," "social legislation," or "assistance for the elderly." *See* 111 CONG. REC. 7228 (1965) (comments of Rep. King); *id.* at 7355 (comments of Rep. Farbstein); *id.* at 15,630 (comments of Sen. Anderson); *id.* at 15,836 (comments of Sen. Kennedy); *id.* at 15,882, 18,513 (comments of Sen. Fong).

Medicaid in no way resembles a program of insurance. It provides federal assistance to states which administer an approved program of health care for the poor and disadvantaged. The *Baylor* court likened it to other assistance programs which were covered by title VI such as the school lunch program. 736 F.2d at 1049; *see also* 42 U.S.C. §§ 1751-1764; *see, e.g.,* 110 CONG. REC. 2487 (1964) (comments of Rep. Celler) (discussion of school lunch program); *id.* at 6545 (comments of Sen. Humphrey); *id.* at 7101 (comments of Sen. Javits); 42 U.S.C. § 291 (1982) (the Hill-Burton program for hospital construction); *see, e.g.,* discussion of Hill-Burton

B. The ADA Applies to Medical Decisionmaking

Arguably, the ADA does not apply to medical treatment decisions. Congress, the argument goes, certainly did not contemplate the ADA intruding upon the practice of medicine. State law currently governs the reasonableness of a medical treatment decision, and federal agencies and courts should not be in the business of creating federal malpractice standards. Moreover, a deviation from acceptable standards is not the kind of "discrimination" that the ADA was intended to prevent. Nor is there any evidence that a federal scheme is needed to protect patients.

Unlike consideration of race, which is unrelated to the choice of a medical treatment, age is generally a relevant consideration. The very existence of specialists in pediatrics and geriatrics is proof of the unique medical needs of different age groups. The United States Court of Appeals for the Second Circuit rejected the applicability of section 504 to medical treatment decisions involving handicapped infants for just this reason: "Where the handicapping condition is related to the condition(s) to be treated, it will rarely, if ever, be possible to say with certainty that a particular decision was 'discriminatory.' "[357]

There is considerable appeal to this argument. Age will often be relevant in medical decisionmaking, and evaluating its relevance is a difficult and highly technical matter that requires the expertise of scientists and physicians. Moreover, state law seems to be an adequate safeguard for the random failure of an individual provider to afford adequate medical care.[358] Nevertheless, the argument that medical decisionmaking is excluded from the scope of the ADA must fail.

In *Bowen v. American Hospital Association*,[359] the Supreme Court was unanimous in its affirmation that "handicapped infants are entitled to 'meaningful access' to medical services provided by hospitals, and . . . a hospital rule or state policy denying or limiting such access would be subject to challenge under Sec. 504."[360] A qualified individual who is not even considered

---

Act, 110 CONG. REC. 1661 (comments of Rep. Lindsay, et al.); *id.* at 6544 (comments of Sen. Humphrey); *id.* at 7063 (comments of Sen. Pastore); *id.* at 13,376 (comments of Sen. Alcott).

357. United States v. University Hosp., 729 F.2d 144, 157 (2d Cir. 1984). Although the court relied upon the "otherwise qualified" language of § 504, its reasoning seems equally applicable to the ADA.

358. *Cf.* Hoyt v. St. Mary's Rehabilitation Center, 711 F.2d 864, 867 (8th Cir. 1983) (dismissal of a § 504 claim alleging that nursing home had discriminated against resident by failing to provide adequate care because "[i]n substance, this is a medical malpractice case").

359. 476 U.S. 610 (1986) (plurality opinion); *see also supra* notes 1-4 and accompanying text.

360. 476 U.S. at 624. There was no majority opinion in *Bowen*. The five to four judgment was announced in a plurality opinion signed by only four justices. Chief Justice Burger con-

for a heart transplant because of his or her age is certainly denied meaningful access to that medical service. The fact that the denial is based upon "medical criteria" devised by physicians should not alter that conclusion.[361]

The fact that age may sometimes be relevant to medical treatment, moreover, does not end the inquiry. With the passage of the ADA, Congress created a presumption against the use of age based upon untested generalizations. The whole purpose of the statute is to test whether, in a given instance, age is a valid criterion.

In *Western Airlines, Inc. v. Criswell,* the employer sought to justify its use of age on the basis of a reasonable medical judgment about the effects of aging.[362] The Supreme Court stated that even reasonable medical judgment would not automatically be accepted, but would be subjected to closer scrutiny.[363] The Court reasoned that, under the ADEA, even a valid generalization would not justify an age test unless a more individualized method of evaluation was unavailable.[364]

Moreover, the fact that age may be relevant in choosing the most appropriate medical treatment does not mean that every use of age as a criterion is influenced only by medical considerations. Physicians are not unlike the rest

---

curred in the result. *Id.* at 648. Three dissenters would have gone even further in upholding the application of § 504 to individual denials of treatment. *Id.* at 650-56 (White, J., dissenting). Justice Rehnquist did not participate in the decision. *Id.* at 648.

361. There is little doubt that the ADA applies to health services, which were specifically mentioned in the 1975 House report. H.R. REP. NO. 67, 94th Cong., 1st Sess. 15 (1975). Moreover, the ADA, as amended by the Civil Rights Restoration Act of 1987, specifically mentions organizations principally engaged in the business of providing health care. Pub. L. No. 100-259, § 5, 1988 U.S. CODE CONG. & ADMIN. NEWS (100 Stat.) 30 (to be codified at 42 U.S.C. § 6107(4)(C)(i)(II)).

In *Bowen,* the American Medical Association argued that § 504 was not applicable to physicians' decisions to deny treatment to handicapped infants in individual cases. Brief for the American Medical Association, at 42-44, Bowen v. American Hosp. Ass'n, 476 U.S. 610 (1986). The Supreme Court avoided this "medical thicket," however, by expressly declining to decide whether § 504 applied to individual treatment decisions. *Bowen,* 476 U.S. at 624.

Nevertheless, the denial of medical treatment on the basis of age certainly comes within the terms of the statutory prohibition. To paraphrase Justice White, dissenting in *Bowen,*

> [t]hat some or most failures to treat may not fall within [the ADA], that discerning which failures to treat are discriminatory may be difficult, and that applying [the ADA] in this area may intrude into the traditional functions of the State do not support the categorical conclusion that the [Act] may never be applied to medical decisions.

Id. at 655-56 (White, J., dissenting).

However difficult it may be to decide whether the ADA governs random medical treatment decisions of individual providers, a hospital's denial of access to a heart transplant program because of the patient's age clearly comes within the protection of the statute.

362. Western Air Lines, Inc. v. Criswell, 472 U.S. 400, 406 (1985); *see also supra* note 262.

363. *Criswell,* 472 U.S. at 423.

364. *Id.* at 422-23.

of the population. They have predispositions and biases. They may see those of advancing age as "a bit crumbly" and, therefore, less likely to be benefitted by medical treatment.[365] This willingness to accept unjustified generalizations about the effects of aging is the very reason the ADA subjects age distinctions to closer scrutiny.

Indeed, physicians may have their own ideas about the efficient use of health care resources. It may seem a better use of resources to preserve the life of one who will live longer and be more productive. Thus, a longevity rationale may be partly responsible for considering age in making a treatment decision. The statute should be applied to expose the basis for using age in treatment decisions.

To be sure, physicians should be given considerable discretion in exercising medical judgment, involving, as it does, a mix of art and science, and of intellect and intuition.[366] The physician should have discretion to weigh the benefits and risks and choose the best treatment for the patient. But where a hospital establishes a treatment protocol that rations medical care, a physician who follows that protocol cannot claim immunity in order to preserve the autonomy of his or her medical judgment. The physician is not deciding what is best for the individual patient; rather, the physician has assumed the responsibility of choosing among patients to decide which patient should be provided care.

The decision to ration, even on the basis of medical criteria, is a policy judgment, not a medical judgment.[367] There is no more reason to insulate the physician's judgment from examination than to insulate the judgment of anyone else. Policy judgments about rationing medical care are not the traditional province of the medical professional. The physician has no particular expertise in this area and, as a consequence, no unusual deference is due his or her decision. While physicians are by no means eager to become rationing agents, if they are forced into that role they will be making social policy decisions. They cannot be considered immune from legal constraints simply because those policy decisions appear in the guise of medical decisions.

The conclusion should not be different where there is no explicit policy of using an age test. The civil rights laws do not distinguish between a stated

365. *See supra* note 84 and accompanying text.

366. *See, e.g.*, E. PELLIGRINO & D. THOMASINA, A PHILOSOPHICAL BASIS OF MEDICAL PRACTICE 70 (1981) ("Clinical judgment is anticipatory, based on the organization of the body, the environment, past clinical experience, values of the patient, and scientific knowledge.").

367. *See supra* note 118 and accompanying text.

policy and a consistent practice that has the same purpose and effect.[368] Explicit policies are easily converted into implicit understandings. For that reason, inquiry into individual decisions should be permitted in order to determine whether the denial of treatment was random or was part of a consistent practice.

The patient selection criteria of a heart transplant program are those of the individual professionals who operate that program. If no individual decisionmaker will consider someone over the age of fifty-five for a transplant, the program must be viewed as having a policy denying access to those above that age.

C. The Use of Age to Exclude Individuals from Consideration for a Heart Transplant May Violate the ADA

The use of age as a criterion to exclude individuals from consideration for heart transplantation violates the basic prohibition of section 6102 of the ADA. A person over the age of fifty-five is "excluded from participation in [a] program or activity receiving Federal financial assistance" and the exclusion is "on the basis of age." The use of age can be upheld only if it comes within one of the statutory exceptions or exemptions of section 6103. Of the five exceptions and exemptions, only the normal operation exception is relevant.[369]

At the outset, subjecting an age criterion to this standard requires an answer to the essential question: Why is the program considering age? With

368. Village of Arlington Heights v. Metropolitan Housing Dev. Corp., 429 U.S. 252, 266 (1977).

369. The use of age as a patient selection criterion for heart transplantation is not authorized by any law. 42 U.S.C. § 6103(b)(2) (1982). Although use of an age criterion is permitted by the 1987 HCFA ruling, *see supra* note 72, this is insufficient to bring the practice within the "any law" exemption. *See supra* notes 248-57 and accompanying text. Nor is it based upon "reasonable factors other than age," 42 U.S.C. § 6103(b)(1)(B), because age "is exactly what it is based on." Los Angeles Dep't of Water & Power v. Manhart, 435 U.S. 702, 713 (1978). In *Manhart,* the Court rejected the argument that since sex was used as a proxy for longevity, sex-based actuarial tables were based on "any factor other than sex" within the meaning of the Equal Pay Act, 29 U.S.C. § 206(d) (1982), and title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e-2(h) (1982). 435 U.S. at 712-13. The similarly worded exception to the ADA is confined to facially neutral criteria which have a disproportionate effect on persons of a particular age. When an age criterion is used as a proxy for some other nonage factor, it is appropriately tested under the normal operation, 42 U.S.C. § 6103(b)(1)(A) (first clause); *see also supra* notes 258-74 and accompanying text, and statutory objective exceptions, 42 U.S.C. § 6103(b)(1)(A) (second clause).

The statutory objective exception does not apply to the use of age in a hospital heart transplant program. The program or activity receiving federal financial assistance is the hospital's program of medical care. That program was not created by, and does not operate pursuant to, a federal statute.

heart transplants, age is being used to ration a limited commodity. Given the limited number of donor hearts available for transplantation, institutions are trying to make wise cost-benefit assessments. Why, then, do they choose age as a rationing criterion?

The expressed rationale for an age test is a medical one. The National Heart, Lung, and Blood Institute's guidelines designate "advancing age" as a contraindication for heart transplantation because, it states, at around age fifty or fifty-five an individual "begins to have a diminished capacity to withstand postoperative complications."[370]

Age does not measure whether an individual is medically unsuitable for a heart transplant. Individuals over the age of fifty-five can, and have, survived heart transplants. Even today, some transplants are being performed on individuals over the age of fifty-five.[371] Indeed, an increase in the availability of donor hearts would undoubtedly lead to a relaxation of this standard by raising the age cut-off.[372] Even medical criteria are responsive to availability, as experience with kidney dialysis demonstrated.[373]

Age is a test, not of absolute, but of relative medical efficacy—to screen out those least expected to achieve clinical success. Early in the days of heart transplant programs, the patient selection criteria were adjusted by lowering the age cut-off because of high rates of morbidity and mortality among those over age fifty.[374]

The National Heart Transplantation Study found a statistically significant correlation between age at the time of transplantation and ability to survive a heart transplant. The study examined 419 individuals who had received heart transplants between 1968 and 1983. In each of several age groups, it compared the number who were alive and the number who had died. Of those ages thirty to thirty-nine at the time they received a transplant, fifty percent were still alive at the time of the study; of those ages forty to forty-nine, thirty-nine percent were still alive; and of those over age fifty, twenty-one percent were still alive.[375]

Thus, age is considered a measure of relative likelihood of survival.

370. 46 Fed. Reg. 7072, 7073 (1981).

371. As of 1985, the Texas Heart Institute had raised its age cut-off to 60. *See* Frazier, *supra* note 326, at 48.

372. THE HASTINGS CENTER, ETHICAL, LEGAL AND POLICY ISSUES PERTAINING TO SOLID ORGAN PROCUREMENT 7 (Oct. 1985) (Report of the Project on Organ Transplantation).

373. *See supra* notes 29-47 and accompanying text.

374. *See* Christopherson, *supra* note 327, at 19.

375. EXECUTIVE SUMMARY, *supra* note 22 at ES-47, Table ES-15. The study does not define survival. Moreover, it measures survival rates based on those who were alive in 1983, without any indication of how long the deceased recipients had lived. For example, an individ-

Transplants are reserved for age groups whose members are, taken as a group, more likely to survive. That reasoning, however, does not fully explain the use of age as an absolute exclusionary factor. Unless age is a controlling factor—because all or substantially all persons over the age of fifty-five are less likely to survive than those who are accepted into the program—the exclusion of those over age fifty-five raises questions about the purpose of an age cut-off.

Why is age used to exclude individuals from consideration when individualized evaluations are being performed anyway?[376] The scientific basis for a total exclusion of those over age fifty-five is admittedly weak.[377]

Physicians may be acting out of an abundance of caution. But in so doing they are also readily accepting untested generalizations about the effects of aging. Moreover, these generalizations correspond with common notions about the "social worth" of older persons. Perhaps the use of an age test reflects, in some part, the desire to save the lives of those who will live longer and lead more productive lives.

The normal operation test must be applied to determine the validity of using a maximum age cut-off to exclude individuals from an opportunity to receive a heart transplant. Certainly, in this instance, a strict application of the standard is appropriate. From the individual patient's standpoint, the consequence of being excluded from the program is certain death.[378]

The test of reasonable necessity requires that the characteristic measured by age be legitimate, that it be essential to the normal operation of the program (without substantially impairing its objectives), that it can be reasonably measured by age, *and* that it would be impractical to measure that characteristic by individualized evaluations.[379] Under the first prong of the

---

ual who received a transplant in 1968 could have lived five years. On the other hand, a recipient of a transplant in 1983 may have lived only one year.

The study concluded that differences based upon age were statistically significant. That is, they did not occur by chance. 3 NATIONAL HEART TRANSPLANTATION STUDY, *supra* note 8, at 21-26.

376. *See supra* notes 326-27 and accompanying text.

377. The only study of the relationship between age and survivability was that conducted by the National Heart Transplantation Study. The study recognized that further investigation was necessary to justify the use of age as a patient selection criterion. 4 NATIONAL HEART TRANSPLANTATION STUDY, *supra* note 8, at 36-34 ("It is important to develop the empirical data that would, in fact, show the relationship between advancing age and successful outcome of cardiac transplantation.").

378. Of course, providing a transplant to one who has little likelihood of surviving is a waste of a very scarce resource. The ADA, however, would not require that every individual over age 55 who could benefit be given a heart transplant. At most, it would require an individualized determination of probability of success.

379. *See supra* notes 258-85 and accompanying text.

normal operation test, the use of an age test to ration heart transplants would appear to violate the ADA if its purpose is to maximize the benefits of the program by limiting transplants to those who, because of their age, are perceived to derive the greatest benefit for the longest period of time. Whether benefit is measured by expected years of extended life or by the value of the individual's life once he or she has reached a certain age, if it is based on the notion that the value of saving the lives of those over the age cut-off is less than the value of saving the lives of younger people, it reflects an illegitimate purpose.

The effect on older individuals is a good reason to view this use of age with skepticism, requiring a close inquiry into the reason for utilizing age. At the same time, age is clearly related to the likelihood of survival and there is probably widespread agreement that medical efficacy is a reasonable basis upon which to ration scarce medical resources.[380] Resolution of the second prong of the normal operations test might turn on whether a court sees the use of age in transplant programs as a measure of social worth or a legitimate factor used to determine medical efficacy. If a court was convinced that targeting by age was really for purposes of medical efficacy, it would be hard pressed to declare such an objective invalid.

---

380. The preamble to the Medicare heart transplant regulations is quite clear in expressing its rationale for strict patient selection criteria: "[T]he use of criteria that would permit the transplantation of hearts to patients with only a small likelihood of survival could lead to circumstances in which a scarce resource would be wasted." *See* HCFA Ruling, *supra* note 72 at 13,625. If the purpose of the age cut-off is to maximize the rate of clinical success by choosing only those who are relatively more likely to survive, it may be an acceptable objective. But, reasonable persons may differ about whether it is *essential* to the normal operation of a heart transplant program. Perhaps all patients who have a reasonable chance of surviving should have an equal opportunity to receive a heart transplant. If age is a reasonable means of measuring probability of success, why has it not been applied as a criterion across the board, giving priority to those who are 30-39 years old?

While the normal operation of a heart transplant program may require rationing, it does not mandate any particular form. There is no consensus on the basis for rationing scarce resources, largely because there has been little rationing of medical care in this country. While physicians have practiced triage when required by emergency situations, even in triage no uniform practice emerges.

"Triage" is the practice of sorting patients according to their medical needs under crisis or emergency conditions, when not all can be treated immediately. Childress, *Triage in Neonatal Intensive Care: The Limitations of a Metaphor,* 69 VA. L. REV. 547, 551 (1983). First developed for use in military situations, it has been extended to civil disasters and emergency rooms. *Id.* at 559. Triage systems are based on a utilitarian rationale: to produce the greatest good for the greatest number, serve the common good, or meet human needs most effectively and efficiently. *Id.* at 551. What is considered efficient, however, may depend upon the context. Although all triage involves sorting patients by need, priorities for treatment may differ. In an emergency room those most in need of medical care will be treated first. *Id.* at 550. Under wartime conditions physicians may first treat those who can be returned to active duty. *Id.* at 551-52.

Under the third prong of the normal operation test, the program must show that age is a good measure of the necessary characteristic. The National Heart Transplantation Study demonstrates a statistically significant relationship between age of transplant recipients and survival. Moreover, the cut-off age of fifty or fifty-five is reasonable in light of the sharp drop in rate of survival between those in the forty to forty-nine age group and those over age fifty.[381] Based upon that professionally conducted study alone, courts might reasonably conclude that the third prong of the test is met. Nevertheless, the data demonstrate that twenty-one percent of those over age fifty survived transplants. Given the consequences to the individual of failure to secure a heart transplant, a court might well conclude that the use of a cut-off of age fifty or fifty-five screens out a substantial number of qualified recipients, and therefore should be struck down.

The fourth prong of the normal operation standard requires a program to forego the use of age unless it is impractical to measure the crucial characteristics by individualized evaluation. Heart transplant programs have other criteria upon which to base an individualized evaluation.[382] If some persons over the age of fifty-five can qualify after individualized evaluation, the ADA seems to prohibit absolute exclusion on the basis of age.

This may be true even if age is relevant to determining relative survivability. If race, for example, measured the relative likelihood of survival, it is unlikely physicians would approve its use without strong evidence that it is an essential means of predicting outcome. Similarly, the ADA, at least in this context, creates a presumption against the unnecessary use of an age test.

The question, then, is whether it is necessary to exclude all individuals over the age of fifty-five from consideration. Certainly, there is some correlation between age and many diseases,[383] some of which are contraindications to heart transplantation.[384] The individualized evaluation, however, is designed to uncover the presence of disease.

What, then, does age tell the physician that cannot be determined through individualized evaluation? With advanced age comes a decrease in something gerontologists call "reserve capacity"—the ability to recover from major surgery.[385] It is not clear whether this is a characteristic that cannot be

---

381. *See supra* note 375 and accompanying text.

382. *See supra* notes 124-26 and accompanying text.

383. *See* Koin, *Surgical Concerns,* in 2 GERIATRIC MEDICINE 275 (C. Cassel & J. Walsh, eds. 1984).

384. *See supra* note 124 and accompanying text.

385. Many physiologic functions decline with age. J. FRIES & L. CRAPO, VITALITY AND AGING: IMPLICATIONS OF THE RECTANGULAR CURVE 32 (1981). Normal, healthy orga-

measured by any means other than an estimate based upon the individual's age. The relevant proxy for this characteristic is not chronologic age, but physiologic age.[386] Moreover, the importance of this factor in the context of heart transplantation has not been explored.

While the age of a prospective heart transplant recipient may provide some information to physicians that the medical examination does not, the importance of that information to accurate prediction of clinical success is unclear.[387] It provides only one piece of a large puzzle. The process of estimating the success of a heart transplant in a given patient is very complex and, while it involves some scientific information, it, like many other medical decisions, is still largely impressionistic.[388] Because there is no formula for making the choice, it is difficult to determine whether the information provided by knowing an individual's age is so important that it should control the decision.[389] Ultimately, this is a question of fact on which experts might differ.

---

nisms maintain an excess reserve capacity beyond immediate functional needs. *Id.* The mean level of reserve in many organs, however, declines with age. *Id.* at 33; *see also* Koin, *supra* note 383, at 275. Healthy organisms, under assault from destructive external forces (such as surgery), regulate their bodily functions through the process of *homeostasis,* to return them to their original integrity. J. FRIES & L. CRAPO, *supra* at 34. The ability of the body to maintain homeostasis declines with decreasing organ reserve. *Id.* When homeostasis cannot be maintained, the organism dies. *Id.* From this, some have argued that diminished physiologic reserve affects the ability of an individual to deal with the stress of surgery. *See* Koin, *supra* note 383, at 275.

Even if it is generally true that those over 50 have diminished reserve capacity, they frequently undergo major surgery. 4 NATIONAL HEART TRANSPLANTATION STUDY, *supra* note 8, at 36-34. Moreover, the rate of decline of physiologic functions differs among individuals and among organisms. J. FRIES & L. CRAPO, *supra* at 34. While some say this decline cannot be quantified, there is some indication that it can be measured in the individual. *See id.* at 33. The variation in physiologic age of healthy people of the same chronologic age is far greater than the variation due to age. Watts & McCally, *Demographic Perspectives,* in 2 GERIATRIC MEDICINE, 3, 7 (C. Cassel & J. Walsh, eds. 1984)

Immunologic function also declines with age. One medical authority, however, points out that there is little evidence linking a depressed immune function with subsequent illness. Goodwin, *Immunology,* in 1 GERIATRIC MEDICINE, 299 (C. Cassel & J. Walsh, eds. 1984) ("Evidence that links depressed or disordered immune function in humans to a subsequent morbidity and/or mortality is scarce. Most authorities simply have assumed that a decline in immune function is deleterious, or they have used theoretic arguments to support this belief.").

386. 4 NATIONAL HEART TRANSPLANTATION STUDY, *supra* note 8, at 36-29.

387. *Id.* at 36-34.

388. D. MECHANIC, *supra* note 90, at 20.

389. Another way of analyzing this issue is to look at age as a measure of "reserve capacity." The question then becomes whether, under the second prong of the test, reserve capacity is a characteristic which must be measured in order to continue the normal operation of the program. If a reasonably accurate evaluation can be made without measuring reserve capacity, age may not be used. This analysis, however, would seem to preclude any consideration of age.

A reasonable interpretation of the ADA would allow physicians to consider age as one factor in the individualized evaluation of medical suitability for a heart transplant, rather than regarding age as an exclusionary criterion precluding individualized evaluation. This interpretation is desirable for a number of reasons. It allows the consideration of a relevant factor which may be otherwise unmeasurable, thus reducing the risk of error, but it does not preclude the otherwise healthy fifty-six or even sixty-five year old from fair consideration. Such an approach serves the purposes of the ADA by avoiding the use of unnecessary generalizations without unduly burdening the program. For this reason, perhaps, the preamble to the HEW regulations favors this approach.[390]

The approach has practical advantages as well. It avoids the need to choose a specific cut-off age, thereby eliminating the arbitrariness of such a choice. Finally, it avoids the appearance of using age as a measure of social worth.[391]

D. The Future Use of Age to Ration Medical Care

Age is currently used to ration heart transplants. Health care providers may be using age to ration other medical care as well. As this Article has discussed, concern about cost containment makes future rationing on the basis of age a real possibility. In each case where a hospital establishes a treatment protocol or engages in a consistent practice of considering a patient's age, that practice is subject to scrutiny under the ADA.

This does not mean that federal law will intrude every time a physician considers the age of his or her patient in deciding upon an appropriate treatment. Individual medical decisions would not be subject to review. However, where physicians engage in a consistent practice of denying patients access to a medical treatment because of their age, the ADA can be invoked.

---

390. The preamble states:

> HEW encourages recipients to apply age distinctions flexibly; that is, to permit a person, upon a proper showing of the necessary characteristic to participate in the activity or program even though he or she would otherwise be barred by the age distinction. Other things being equal, an age distinction is more likely to qualify under one of the statutory exceptions if it does not automatically bar all those who do not meet the age requirements.

44 Fed. Reg. at 33,773 (1979).

391. Of course, it can be argued that consideration of age as one factor leaves open the possibility of more subtle discrimination which still operates to exclude individuals on the basis of age. Nevertheless, this is preferable to use of an age-based criterion which inevitably leads to exclusion on the basis of age. Without reason to conclude otherwise, we should presume the good faith of physicians in applying a facially neutral process which weighs age fairly against other factors. *Cf.* Regents of the Univ. of Calif. v. Bakke, 438 U.S. 265, 318 (Powell, J. concurring).

Such a consistent practice denies the excluded individual meaningful access to treatment at that hospital.[392] The fact is, however, that the impetus for rationing is more likely to come from hospital administrators concerned about budgetary problems, than it is to come from physicians, who are reluctant rationing agents.

The results of such scrutiny will not always be the same.[393] Each time an inquiry is made into a particular use of an age criterion, two issues arise. First, is age being used as a rationing device? Second, is age a necessary medical criterion or would some other criterion be an adequate substitute?

A hospital may not wish to acknowledge that it is rationing and will attempt to justify the use of an age criterion on other grounds. But unless a medical treatment would not possibly be beneficial, rationing seems to be the only justification for limiting its availability on the basis of age. Thus, if the hospital is to uphold its selection criteria, it will be forced to admit that it is rationing.

The result, under the ADA, is not certain. A court may find that a hospital has no choice but to ration if, as with heart transplants, there is a natural scarcity of critical medical resources. That conclusion might be different,

---

392. Hospitals have general authority to grant or deny staff privileges. *See generally* Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 ST. LOUIS U.L.J. 452 (1978). Whatever the limits to this authority, it would seem to extend to denying privileges to those who are engaging in unlawful discrimination.

393. Of course, the result of scrutinizing explicit age criteria may be the adoption of objective criteria which have a disproportionate impact on older persons as a group. This should not be a significant concern.

The statute creates an exception for age distinctions based upon "reasonable factors other than age." 42 U.S.C. § 6103(b)(1)(B) (1982). The HEW regulations require that a neutral factor which has an adverse impact on a given age group, may not be sustained unless it bears a "direct and substantial relationship to the normal operation of [a] program or activity." 45 C.F.R. § 90.15 (1987). The EEOC ADEA regulations interpret a similarly worded statutory exception to require that the nonage factor be justified by "business necessity." 29 C.F.R. § 1625.7(d) (1987). While the HEW test is somewhat less stringent than that for the ADEA, it still seems to be an inappropriate interpretation of the ADA because it essentially imposes an "effects" test.

A test of rationality seems more consistent with the language and purposes of the ADA. The statute refers to "reasonable" factors other than age. The evil at which the ADA was primarily directed was not prejudice against any age group, but, rather, the unquestioning acceptance of untested generalizations about age. Congress rejected the Civil Rights Commission's definition of age discrimination as any action with an adverse effect on any age group. Only where the use of objective factors is a pretext for discrimination on the basis of age should that use be struck down under the ADA, such as where a hospital can show no reasonable basis for use of the factor. The burden of showing the reasonableness of the factors should remain on the program which employs them. Of course, the longevity rationale cannot be upheld as a reasonable factor other than age. Moreover, a cost rationale cannot be considered reasonable when it singles out those of a particular age group because they are more costly to serve. *See supra* note 365 and accompanying text.

however, if the scarcity is created artificially through budget restraints on health providers. Under such circumstances, rationing is more difficult to justify as a valid program objective, especially if the rationed treatment is life-saving. Common acceptance of the "life-saving imperative" could make rationing an improper purpose of the medical program of a hospital. The very fact that the rationing has been hidden may convince a court that it is not a valid program objective. On the other hand, a court might reject this argument as judicial overreaching; the antidiscrimination laws were not intended to control neutral program objectives, but simply to assure the even-handed treatment of individuals within the confines of a given program.

In each case, the court will then need to examine the use of age as a rationing criterion. The court will focus on separating the use of age as a measure of medical efficacy from other uses. Age requirements based upon longevity or other social worth rationales will be invalidated. The validity of using age as a medical criterion will depend upon the condition being treated and the extent of scientific knowledge and medical experience. Health providers will not be able to rely upon untested generalizations. With the growth of scientific knowledge about aging, and its effects, the results may change. As the National Heart Transplantation Study noted, more research is needed to justify the use of age as a patient selection criterion.[394]

Judicial inquiry into these issues may result in striking down some hospital protocols. Even where they are upheld, however, the very fact that hidden rationing is exposed will have an impact on health care policy. When these issues are aired publicly, rationing will survive only if a consensus develops on the need to ration and the means by which rationing decisions should be made. Society may reject cost containment efforts because of their effect on the availability of medical care to the elderly and other disadvantaged groups. Or it may decide that some rationing is necessary. For example, society may decide that we should devote fewer resources to prolonging the life of terminally ill patients.

If society chooses to ration, medical efficacy is a fair basis for deciding who should receive medical care. We will want physicians to be central to the decisionmaking process. What we should not accept, however, is hidden rationing where health providers alone are making all of the decisions about what to ration and who to exclude.

As difficult as it may be for Congress to adopt a rationing scheme, the legislature is the most appropriate forum for examining competing concerns and interests, and for formulating a policy which reflects a consensus. If society cannot adopt a rationing policy openly, it should not do so at all.

394. 4 NATIONAL HEART TRANSPLANTATION STUDY, *supra* note 8, at 36-34.